# Seizure Observation Record

**Student Name:**

**Date & Time**

**Seizure Length**

**Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)**

**Conscious (yes/no/alttered)**

**Injuries? (briefly describe)**

**Muscle Tone/Body Movements**

- Rigid/clenching
- Limp
- Fell down
- Rocking
- Wandering around
- Whole body jerking

**Extremity Movements**

- (R) arm jerking
- (L) arm jerking
- (R) leg jerking
- (L) leg jerking
- Random Movement

**Color**

- Bluish
- Pale
- Flushed

**Eyes**

- Pupils dilated
- Turned (R or L)
- Rolled up
- Staring or blinking (clarify)
- Closed

**Mouth**

- Salivating
- Chewing
- Lip smacking

**Verbal Sounds (gagging, talking, throat clearing, etc.)**

**Breathing (normal, labored, stopped, noisy, etc.)**

**Incontinent (urine or feces)**

**Post-Seizure Observation**

- Confused
- Sleepy/tired
- Headache
- Speech slurring
- Other

**Length of Time before Orientation**

**Parents Notified? (time of call)**

**EMS Called? (call time & arrival time)**

**Observer’s Name**

*Please put additional notes on back as necessary.*