Health Tracking: Seizure

Section 1-General Information Entry Date & Time:_____

Individual Name: * _____ Program Name: * _____Time zone: _____

Date:* _____Entered By:_____Reported By: * _____

Notification Level: □ Low □ Medium □ High

Section 2-Seizure Information

If not a Program site: □ Community □ Family Home Visit □ Recreation/Leisure □ Vehicle □ Other

Other:_____

Begin Time: _____am/pm Seizure Duration _____Min _____Sec

Description:

□ Biting of tongue/lips □ Chewing/ Lip smacking □ Crying Out □ Dancing or Twirling □ Drooling □ Eyes downward □ Eyes upward □ Falling to the floor □ Fidgeting with objects □ Head and eyes turned to the left □ Head and eyes turned to the right □ Head Drop □ Jerking while conscious □ Jerky arm movements left side □ Jerky arm movements right side □ Limp body □ Loss of bladder control □ Loss of bowel control □ Nausea/Vomiting □ Picking at clothes/ taking off clothes □ Rapid blinking of eyes and/or small twitching movements □ Rigid body □ Running □ Staring spell □ Sudden dropping of objects □ Unconscious □ Unresponsive □ Violent shaking of entire body

Other:_____

Respiration: □ Absent □ Deep □ Fast □ Normal □ Shallow □Slow

Skin Color: □ Ashen □ Cyanotic □ Flushed □ Pale □ Pink

Behavior after Seizure:

□ Complaints of headache □ Confused □ Deep Sleep □ Dizziness □ Drowsiness □ Fever □ Inability to walk or stand □ Irritability □ Problems with vision □ Return to activity engaged in prior to seizure

Other:_____

Staff Action:

□ Used Vagus Nerve Stimulator □ Turned person to side □ Placed soft material under head □ Loosened clothing around neck □ Contacted Emergency Services □ Maintained safe environment □ Administered Diazepam Rectal Gel (Diastat AcuDial) □ Contacted Nurse □ Contacted Doctor

Other:_____

Precipitating Factors:_____

_____

_____

Resulting Injuries: _____

_____

_____

Comments: _____

_____

_____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)