SEIZURE RECORD

Name of Resident _____ Date _____

Time _____

OBSERVATIONS PRIOR TO SEIZURE (activity, attitude, behavior, etc.):

_____

_____

_____

ACTIVITY DURING SEIZURE (first movement is most important; e.g., right hand, left leg):

_____

_____

_____

_____

DURATION OF SEIZURE (seconds, minutes): _____

ACTIVITY AFTER SEIZURE (awareness, speech difficulty, etc.): _____

_____

_____

_____

_____

LENGTH OF TIME UNTIL RESIDENT RETURNED TO NORMAL BEHAVIOR: _____

_____

DESCRIBE ANY INJURIES THAT OCCURRED DUE TO THE SEIZURE AND TREATMENT GIVEN:

_____

_____

1. If a resident has more than two (2) seizures in a day, call his doctor.
2. If a resident has three (3) or more seizures in a week, notify his doctor.
3. If the jerking of the body lasts more than five (5) minutes or keeps recurring, obtain medical assistance.
4. Deal with the seizure as advised in "Epilepsy First Aid" from the Epilepsy Association of Central Ohio, Inc.

_____ _____

Date Signature of Staff