

# Seizure Description Sheet



Childs Name \_\_\_\_\_

Person Filling Out Form \_\_\_\_\_

## EVENT DETAILS

Date completed: \_\_\_\_\_

Date of seizure/event: \_\_\_\_\_

Time seizure/event started: \_\_\_\_\_

Time seizure/event ended: \_\_\_\_\_

How long did it last?  
\_\_\_\_\_

## DETAILS

Where did it happen? \_\_\_\_\_

Who witnessed it? \_\_\_\_\_

Note:  
\_\_\_\_\_

## WHAT WAS HAPPENING BEFORE THE SEIZURE?

Check any that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sleeping                | <input type="checkbox"/> Crying or upset               | <input type="checkbox"/> Constipation or pain |
| <input type="checkbox"/> Waking up               | <input type="checkbox"/> Fever or illness              | <input type="checkbox"/> Overstimulated       |
| <input type="checkbox"/> Playing                 | <input type="checkbox"/> Recently missed sleep         | <input type="checkbox"/> Unknown              |
| <input type="checkbox"/> Eating or drinking      | <input type="checkbox"/> Recently missed medication    | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Bathing                 | <input type="checkbox"/> New medication or dose change | _____   |
| <input type="checkbox"/> In car seat or stroller |  |   |
| <input type="checkbox"/> Watching screen         |  |   |





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## AWARENESS AND RESPONSIVENESS

During the seizure, the child was:

- Fully aware
- Partly aware
- Not aware
- Not responding
- Eyes open but not responding
- Eyes closed
- Seemed confused
- Unknown

## COULD THEY RESPOND TO VOICE OR TOUCH?

- Yes
- No
- Somewhat
- Unknown

Note:

## WHAT DID THEY RESPOND TO, IF ANYTHING?

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WAS RESCUE MEDICATION GIVEN?	
<input type="checkbox"/> Yes	
<input type="checkbox"/> No	
<input type="checkbox"/> Not prescribed	
<input type="checkbox"/> Not sure	
Did it help?	

RESCUE MED INFO	
Medication name: _____	
Dose: _____	
Time given: _____	
Note:	

OTHER STEPS TAKEN:	
<input type="checkbox"/> Timed seizure	
<input type="checkbox"/> Turned onto side	
<input type="checkbox"/> Repositioned airway	
<input type="checkbox"/> Gave oxygen	
<input type="checkbox"/> Suctioned	
<input type="checkbox"/> Called nurse or caregiver	
<input type="checkbox"/> Called emergency services	
<input type="checkbox"/> Went to hospital	
<input type="checkbox"/> Other: _____	

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WHAT HAPPENED AFTER THE SEIZURE?	
Check any that apply:	
<input type="checkbox"/> Slept deeply	<input type="checkbox"/> Breathing still
<input type="checkbox"/> Confused	<input type="checkbox"/> abnormal
<input type="checkbox"/> Crying	<input type="checkbox"/> Oxygen still low
<input type="checkbox"/> Irritable	<input type="checkbox"/> Heart rate still
<input type="checkbox"/> Weak	<input type="checkbox"/> unusual
<input type="checkbox"/> One-sided weakness	<input type="checkbox"/> Pale, blue, gray, or
<input type="checkbox"/> Vomited	<input type="checkbox"/> dusky
<input type="checkbox"/> Headache	<input type="checkbox"/> Back to baseline fast
<input type="checkbox"/> Took a long time to return to baseline <input type="checkbox"/> Did not return to baseline <input type="checkbox"/> Another seizure happened <input type="checkbox"/> Other:	

OTHER
How long until they returned to baseline?
What was different from their usual recovery?
Note:

POSSIBLE TRIGGERS OR PATTERNS	
Check any that may apply:	
<input type="checkbox"/> Fever	<input type="checkbox"/> Dehydration
<input type="checkbox"/> Illness	<input type="checkbox"/> Overheating
<input type="checkbox"/> Pain	<input type="checkbox"/> Flashing lights or screen
<input type="checkbox"/> Constipation	<input type="checkbox"/> Stress or crying
<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Menstrual cycle
<input type="checkbox"/> Missed medication	<input type="checkbox"/> Growth or weight change
<input type="checkbox"/> Medication change	<input type="checkbox"/> Unknown
<input type="checkbox"/> Feeding issue	<input type="checkbox"/> Other:

