Entry Date and Time: ……
mm/dd/yyyy

Data Collection for Seizures Form

Section 1 - General Information

Individual Name:* ……

Program Name: …… Time Zone: ……

Entered By: …… Date:* ……..
mm/dd/yyyy

Reported By:* ……

Notification Level: ○ Low ○ Medium ○ High

Section 2 - Seizure Information

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

If Other ……

Begin Time: …… : …… ☐ am ☐ pm Seizure Duration: …… Min …… Sec

Description:

☐ Biting of tongue/lips ☐ Chewing/ Lip smacking ☐ Crying Out
☐ Dancing or Twirling ☐ Eyes downward ☐ Drooling
☐ Falling to the floor ☐ Eyes upward ☐ 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

If 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

If Other: .....

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

If Others: .....

Precipitating Factors:

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Resulting Injuries:

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Comments:

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

