SCHOOL SEIZURE LOG

Name of Student (Last, First, MI)		Birthdate	School Year
School	Grade	Teacher	

Please print clearly using black ink or dark pencil. Form may be copied for parents and/or physician. When form has been completed, please file in student medical folder and begin a new record.

NOTE: Notify nurse if there is a change in the duration, frequency, or pattern of seizure activity. **Call 9-1-1** if seizure lasts longer than 5 minutes, if there is any impairment of breathing or if student continues to go in and out of seizures. Check boxes below which best describes seizure activity.

Date	Time	Duration Min/Sec (use your watch)	Body			Eyes				Skin					No Response to Verbal Stimuli	No Response to All Stimuli	Fell During Seizure	Incontinent of BM or Urine	Sleeping Afterwards (How Long)	**ACTIONS TAKEN / COMMENTS** (e.g. child's comments, sequence of symptoms, aura, illness, fever, injury, first aid, recent Rx change, parent / 911 called etc.)	Initials
			Stiffening (Tonic)	Jerking (Clonic)	Limp (Tone Loss)	Rolled Back	Staring	Turn to Side	Pupil Change	Blue Lips	Grayish	Paler	Flushed	No Change							

Signature ______________________ Initials ______

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Signature ______________________ Initials ______

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3/28/24