SEIZURE RECORD

Client Name:_____ Date of Birth:_____

Date	Time	Description of Seizure/Medication or Treatment

Instructions: Care provider describes what happened before, during, and after seizure. Did eyes roll, face twitch, or head jerk? Did consumer fall down, lose consciousness, wet himself/herself? Did any or all extremities shake? When seizure was over was consumer alert, sleepy, or confused? Note how long seizure lasts. Note if the seizure is the same as, or different from usual seizure activity. If different, the doctor should be notified.

Take This Record to the Physician When The Resident Is Being Seen