Seizure observation and treatment form

Young Epilepsy

Please refer to the child's Individual Healthcare Plan, including their emergency protocol, when responding to seizures.

Name: _____

Before the seizure

Symptoms/feelings before the seizure:

◯ Anxious ◯ Tired ◯ Stressed ◯ Irritable ◯ Impulsive ◯ Nauseous

◯ Strange sensations Other: _____ ◯ None

Position at start of seizure:

◯ Sitting ◯ Standing ◯ Lying Other: _____

During the seizure

Date: _____

Time at onset: _____ Time at end of seizure: _____ Duration of seizure: _____

Did the child fall? ◯ Yes ◯ No ◯ Forwards ◯ Backwards

Description: _____

Breathing: ◯ Rapid ◯ Shallow ◯ Deep ◯ Laboured Other: _____

Colour (note any changes in skin tone, particularly around the mouth and extremities):

_____

Describe any movements of:

Head: _____

Arms: _____

Legs: _____

Eyes: ◯ Deviated to the left ◯ Deviated to the right ◯ Pupils dilated

Other: _____

Level of awareness/responsiveness: ◯ Fully aware ◯ Reduced awareness

◯ Responsive to voice ◯ Responsive to touch ◯ No response

Any injury: ◯ Tongue ◯ Limbs ◯ Head Other: _____

Incontinence: Urinary: ◯ Yes ◯ No Faecal: ◯ Yes ◯ No

Action taken:

_____

_____

_____

_____

Emergency medication given (if applicable)

◯ Yes ◯ No

Dosage: _____

Time of administration: _____

Name of person who administered the medication: _____

Time ambulance called (if required): _____

Additional comments: _____

_____

_____

Parents informed: _____ Signed: _____

Print name: _____ Date: _____

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