**SCHOOL SEIZURE LOG**

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.

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

**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.

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| Date | Time | DurationMin/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 |
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Signature Initials Signature Initials

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