

**CARROLL COUNTY PUBIC SCHOOLS
SEIZURE ASSESSMENT RECORD**

SCHOOL: _____

Name: _____ Date: _____ Time of Seizure: _____ Length of Seizure: _____

Time	Initial Assessment	Re-Assessment: _____	Re-Assessment: _____	Re-Assessment: _____	Re-Assessment: _____
LOC	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Unresponsive <input type="checkbox"/> Sedate <input type="checkbox"/> Combative <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike
Eye Movement	<input type="checkbox"/> Pupils Dilated <input type="checkbox"/> Turned R ____ L ____ <input type="checkbox"/> Rolled Upwards <input type="checkbox"/> Twitching <input type="checkbox"/> Blinking <input type="checkbox"/> Staring <input type="checkbox"/> Closed	<input type="checkbox"/> Pupils Dilated <input type="checkbox"/> Turned R ____ L ____ <input type="checkbox"/> Rolled Upwards <input type="checkbox"/> Twitching <input type="checkbox"/> Blinking <input type="checkbox"/> Staring <input type="checkbox"/> Closed	<input type="checkbox"/> Pupils Dilated <input type="checkbox"/> Turned R ____ L ____ <input type="checkbox"/> Rolled Upwards <input type="checkbox"/> Twitching <input type="checkbox"/> Blinking <input type="checkbox"/> Staring <input type="checkbox"/> Closed	<input type="checkbox"/> Pupils Dilated <input type="checkbox"/> Turned R ____ L ____ <input type="checkbox"/> Rolled Upwards <input type="checkbox"/> Twitching <input type="checkbox"/> Blinking <input type="checkbox"/> Staring <input type="checkbox"/> Closed	<input type="checkbox"/> Pupils Dilated <input type="checkbox"/> Turned Right <input type="checkbox"/> Turned Left <input type="checkbox"/> Rolled Upwards <input type="checkbox"/> Twitching <input type="checkbox"/> Blinking <input type="checkbox"/> Staring <input type="checkbox"/> Closed
Muscle Tone/ Body Movements	<input type="checkbox"/> Rigid/Clenching <input type="checkbox"/> Limp <input type="checkbox"/> Fell Down <input type="checkbox"/> Rocking <input type="checkbox"/> Wandering Around <input type="checkbox"/> Whole Body Jerking <input type="checkbox"/> Purposeful Movement	<input type="checkbox"/> Rigid/Clenching <input type="checkbox"/> Limp <input type="checkbox"/> Fell Down <input type="checkbox"/> Rocking <input type="checkbox"/> Wandering Around <input type="checkbox"/> Whole Body Jerking <input type="checkbox"/> Purposeful Movement	<input type="checkbox"/> Rigid/Clenching <input type="checkbox"/> Limp <input type="checkbox"/> Fell Down <input type="checkbox"/> Rocking <input type="checkbox"/> Wandering Around <input type="checkbox"/> Whole Body Jerking <input type="checkbox"/> Purposeful Movement	<input type="checkbox"/> Rigid/Clenching <input type="checkbox"/> Limp <input type="checkbox"/> Fell Down <input type="checkbox"/> Rocking <input type="checkbox"/> Wandering Around <input type="checkbox"/> Whole Body Jerking <input type="checkbox"/> Purposeful Movement	<input type="checkbox"/> Rigid/Clenching <input type="checkbox"/> Limp <input type="checkbox"/> Fell Down <input type="checkbox"/> Rocking <input type="checkbox"/> Wandering Around <input type="checkbox"/> Whole Body Jerking <input type="checkbox"/> Purposeful Movement
Extremity Movements	<input type="checkbox"/> Arm Jerking R__ L__ <input type="checkbox"/> Leg Jerking R__ L__ <input type="checkbox"/> Random Movements	<input type="checkbox"/> Arm Jerking R__ L__ <input type="checkbox"/> Leg Jerking R__ L__ <input type="checkbox"/> Random Movements	<input type="checkbox"/> Arm Jerking R__ L__ <input type="checkbox"/> Leg Jerking R__ L__ <input type="checkbox"/> Random Movements	<input type="checkbox"/> Arm Jerking R__ L__ <input type="checkbox"/> Leg Jerking R__ L__ <input type="checkbox"/> Random Movements	<input type="checkbox"/> Arm Jerking R__ L__ <input type="checkbox"/> Leg Jerking R__ L__ <input type="checkbox"/> Random Movements
Color	<input type="checkbox"/> Bluish <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Unchanged	<input type="checkbox"/> Bluish <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Unchanged	<input type="checkbox"/> Bluish <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Unchanged	<input type="checkbox"/> Bluish <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Unchanged	<input type="checkbox"/> Bluish <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Unchanged
Breathing	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Noisy <input type="checkbox"/> Irregular <input type="checkbox"/> Stopped	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Noisy <input type="checkbox"/> Irregular <input type="checkbox"/> Stopped	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Noisy <input type="checkbox"/> Irregular <input type="checkbox"/> Stopped	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Noisy <input type="checkbox"/> Irregular <input type="checkbox"/> Stopped	<input type="checkbox"/> Normal <input type="checkbox"/> Labored <input type="checkbox"/> Noisy <input type="checkbox"/> Irregular <input type="checkbox"/> Stopped
Mouth/Verbal Sounds	<input type="checkbox"/> Salivating <input type="checkbox"/> Chewing <input type="checkbox"/> Lip Smacking <input type="checkbox"/> Gagging <input type="checkbox"/> Talking <input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Salivating <input type="checkbox"/> Chewing <input type="checkbox"/> Lip Smacking <input type="checkbox"/> Gagging <input type="checkbox"/> Talking <input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Salivating <input type="checkbox"/> Chewing <input type="checkbox"/> Lip Smacking <input type="checkbox"/> Gagging <input type="checkbox"/> Talking <input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Salivating <input type="checkbox"/> Chewing <input type="checkbox"/> Lip Smacking <input type="checkbox"/> Gagging <input type="checkbox"/> Talking <input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Salivating <input type="checkbox"/> Chewing <input type="checkbox"/> Lip Smacking <input type="checkbox"/> Gagging <input type="checkbox"/> Talking <input type="checkbox"/> Throat Clearing
Speech	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible	<input type="checkbox"/> Clear & Understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Difficult to Comprehend <input type="checkbox"/> Non-Sensible
Other	<input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of Urine <input type="checkbox"/> Incontinent of Feces	<input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of Urine <input type="checkbox"/> Incontinent of Feces	<input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of Urine <input type="checkbox"/> Incontinent of Feces	<input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of Urine <input type="checkbox"/> Incontinent of Feces	<input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of Urine <input type="checkbox"/> Incontinent of Feces
Post-Seizure Behavior	<input type="checkbox"/> Confused <input type="checkbox"/> Sleepy/Tired <input type="checkbox"/> Headache <input type="checkbox"/> Irritable <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confused <input type="checkbox"/> Sleepy/Tired <input type="checkbox"/> Headache <input type="checkbox"/> Irritable <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confused <input type="checkbox"/> Sleepy/Tired <input type="checkbox"/> Headache <input type="checkbox"/> Irritable <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confused <input type="checkbox"/> Sleepy/Tired <input type="checkbox"/> Headache <input type="checkbox"/> Irritable <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Confused <input type="checkbox"/> Sleepy/Tired <input type="checkbox"/> Headache <input type="checkbox"/> Irritable <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____

Comments: _____

Name of Parent/Guardian Contacted: _____

Time: _____

Signature of Person Witnessing Seizure

Signature of School Nurse