Green Mountain Support Services
Seizure Activity Report

Date of seizure: _____Client: _____DOB: _____Allergies: _____
Service Coordinator: _____

Time seizure occurred: _____ Time seizure ended: _____ Duration of seizure: _____

Place seizure occurred: _____

Describe activities prior to seizure: _____
_____
_____
_____
_____

Please check all descriptions that apply:

Position prior to seizure: __Standing __Sitting __Walking __Lying __Other (Describe):	**Breathing during seizure:** __Normal __Rapid __Labored /difficult __Stopped (How long): __Other (Describe):	**Continent:** **Incontinent:** __Bowel __Bowel __Bladder __Bladder __Both __Both
Skin color prior to seizure: __Normal __Flush __Pale __Grey __Blue __Other (Describe):	**Status of eyes during seizure:** __Open __Closed __Rolled (up or down) __Deviated (left or right) (one or both) __Other (Describe):	**First Aid:** __Followed individualized seizure plan __Stayed with client in safe area __Protected head __Loosened clothing __Assisted to one side __Other (Describe):
Other descriptions: __Sweating __Excess drooling __Personality change __Other (Describe):	**Extremities involved during seizure (jerking, etc.):** __Arms __Legs __Both __Other (Describe):	**Status after seizure (postictal):** __Alert __Drowsy __Confused __Other (Describe):

Please describe any injuries: _____
_____
Please describe post seizure care: _____
_____
911 Called: Yes or No (Circle one) Critical Incident Report completed: Yes or No (Circle one)

Individual completing report: _____Date completed: _____

Individual(s) that witnessed seizure: _____

Seizure reported to: _____ Date submitted: _____