



























SEIZURE DESCRIPTION SHEET

Directions: Please check (✓) what happens (or happened) during your child's seizure and bring this sheet to your child's neurology appointment.

— DESCRIPTION OF SPELL OR SEIZURE —

 <p>Body</p>	<input type="checkbox"/> whole	 <input type="checkbox"/> right	 <input type="checkbox"/> left	<input type="checkbox"/> can't tell ?
 <p>Movement</p>	<input type="checkbox"/> jerking 	<input type="checkbox"/> stiffness 	<input type="checkbox"/> jerking and stiffness 	<input type="checkbox"/> can't tell ?
 <p>Eyes</p>	<input type="checkbox"/> up 	<input type="checkbox"/> closed 	<input type="checkbox"/> right → 	<input type="checkbox"/> left ← 
	<input type="checkbox"/> stare 	<input type="checkbox"/> stare and blink 	<input type="checkbox"/> no change 	<input type="checkbox"/> can't tell ?
 <p>Skin Color</p>	<input type="checkbox"/> blue 	<input type="checkbox"/> no change 	<input type="checkbox"/> can't tell ?	
 <p>Accident</p>	<input type="checkbox"/> pee - pee 	<input type="checkbox"/> poop 	<input type="checkbox"/> none	<input type="checkbox"/> can't tell ?
 <p>Mouth</p>	<input type="checkbox"/> dry 	<input type="checkbox"/> drool 	<input type="checkbox"/> foam 	<input type="checkbox"/> bite tongue 
	<input type="checkbox"/> can't tell ?			
<p>How Often</p>	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly	<input type="checkbox"/> other: _____

— AFTER SEIZURE OR SPELL —

<input type="checkbox"/> asleep 	<input type="checkbox"/> drowsy 	<input type="checkbox"/> alert 	<input type="checkbox"/> confused 	<input type="checkbox"/> paralyzed 
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