

**Greenville County Disabilities and Special Needs Board
Seizure Report**

Name: _____ Date: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Community	Time: _____ AM/PM Duration of Seizure _____ <input type="checkbox"/> Residence _____
Place Seizure Occurred (exact Location): _____	
Communication Deficit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vocal <input type="checkbox"/> Gestures <input type="checkbox"/> Sign Language	
Mental Status (during Seizure) <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Dreamlike <input type="checkbox"/> Unconscious <input type="checkbox"/> Agitated <input type="checkbox"/> Vacant	Skin Color/Complexion: <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Blue <input type="checkbox"/> Clammy
Eyes: <input type="checkbox"/> Rolled Up <input type="checkbox"/> Turned Left <input type="checkbox"/> Rolled Down <input type="checkbox"/> Turned Right <input type="checkbox"/> Crossed	Mouth: <input type="checkbox"/> Salivated <input type="checkbox"/> Grind Teeth <input type="checkbox"/> Smacked Lips <input type="checkbox"/> Talked <input type="checkbox"/> Swallowed <input type="checkbox"/> Cried <input type="checkbox"/> Chewed <input type="checkbox"/> Bit Lip <input type="checkbox"/> Bit Tongue <input type="checkbox"/> Locked Jaws
Sphincters: <input type="checkbox"/> Defecated <input type="checkbox"/> Urinated	
Movement: <input type="checkbox"/> Jerked <input type="checkbox"/> Whole Body <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> Trembling <input type="checkbox"/> Purposeful Movement <input type="checkbox"/> Jackknife Movements	
Muscle Tone: <input type="checkbox"/> Rigid <input type="checkbox"/> Whole Body <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> Limp <input type="checkbox"/> Whole Body <input type="checkbox"/> RA <input type="checkbox"/> RL <input type="checkbox"/> LA <input type="checkbox"/> LL <input type="checkbox"/> Fell Down - Location _____	
Breathing: <input type="checkbox"/> Stopped for _____seconds <input type="checkbox"/> Became Noisy <input type="checkbox"/> Deep Breaths	
Behavior Afterward: <input type="checkbox"/> Usual <input type="checkbox"/> Drowsy <input type="checkbox"/> Deep Sleep <input type="checkbox"/> Talking <input type="checkbox"/> Confused <input type="checkbox"/> Irritable	
Below describe any apparent injuries. Add information not listed above. _____ _____	
Signature/Title: _____ Date _____ Time _____ AM/PM	
Name of Supervisor _____	Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ AM/PM
Name of Nurse _____ (for ICF consumers only)	Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ AM/PM
Parent/Guardian _____	Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ AM/PM
EMS _____	Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ AM/PM
Physician _____	Notified <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ AM/PM