Public Health
Seattle & King County

SEIZURE ACTIVITY LOG

Note: This should be accompanied by an established *Seizure Care Plan* on-file for this child.

Name of Child: _____ **Date of Birth:** _____ **Room:** _____

DATE	TIME OF SEIZURE	CIRCUMSTANCES BEFORE (activity participating in)	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF NAME (person making entry)

***What to look for and note above:**

1. Sudden Stare
2. Unresponsive to name
3. Picking or fumbling movements of hands
4. Prompt recovery (seconds)
5. Gradual recovery (minutes)
6. Slow recovery (confused/ needing sleep)
7. Clenched jaw or tongue bitten
8. Unconsciousness
9. Color change or breathing problem
10. Stiff and/or jerky movements
11. Lip smacking
12. Eye fluttering