LOS ANGELES UNIFIED SCHOOL DISTRICT District Nursing Services

SEIZURE RECORD

Name	Birth date	School							
(\checkmark) applicable columns, make notations as appropriate e	oplicable columns, make notations as appropriate especially any changes observed.								

Note: Make copy for parent

Date	Time	Duration (Min:sec)	Stiffening	Jerking	Limp	Extremities Involved (RA: Rt arm; LA: Lt arm; RL: Rt leg; LL: Lt leg)	No response to verbal stimuli	Fell during seizure	Incontinent: urine	Staring eyes	Sleeping afterwards	Nurse notified	Parent notified	Comments (e.g., aura, sequence of seizure, changes in skin color, injury, etc. Indicate return to class or sent home)	Signature