



SEIZURE TRACKING CHART (detailed)

Name:	DOB:
Month/Year:	
Seizure Medication(s)/Dosage(s)/Schedule(s):	
Neurologist/Primary Care Physician:	
Contact Information:	

Seizure Management Plan
<input type="checkbox"/> If two or more seizures occur without recovery of consciousness (obeys commands or gives meaningful response to a question), then:
<input type="checkbox"/> If a single seizure lasts longer than _____ minutes, then:
Who to Call:

DATE/TIME	DURATION	DESCRIPTION—CHECK ALL CONDITIONS OBSERVED				MEDICATION(S) ADMINISTERED	VITAL SIGNS	INITIALS
	_____ <input type="checkbox"/> Seconds <input type="checkbox"/> Minutes	<input type="checkbox"/> Aura <input type="checkbox"/> Blank stare <input type="checkbox"/> Fall <input type="checkbox"/> Lips/nose blue	<input type="checkbox"/> Rapid eye movement <input type="checkbox"/> Sleep after seizure <input type="checkbox"/> Vomiting after seizure <input type="checkbox"/> Wet pants	Twitching: <input type="checkbox"/> Eyelid: R / L <input type="checkbox"/> Face: R / L <input type="checkbox"/> Other: see notes	Jerking: <input type="checkbox"/> Arm: R / L <input type="checkbox"/> Leg: R / L			
Notes/Precipitating Event(s):						Who Was Notified:		
DATE/TIME	DURATION	DESCRIPTION—CHECK ALL CONDITIONS OBSERVED				MEDICATION(S) ADMINISTERED	VITAL SIGNS	INITIALS
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Who Was Notified:

Revised: 4-4-2014