Public Health
Seattle & King County

Seizure Activity Log

This form should be stored with the child's Seizure Care Plan.
Please share this log with the child's parent or guardian so they can share it with the healthcare provider.

Child's name: _____

Child's date of birth: _____

Date	Time of Seizure		What Happened Before Seizure Began	Seizure Symptoms*	Behavior after Seizure**	Actions Taken by Staff	If Applicable		Name of Person Documenting
	Start	End					Time Medication Given***	Time 911 Called	

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***Seizure Symptoms:**

- Sudden stare
- Unresponsive to name
- Clenched jaw or tongue bitten
- Unconsciousness
- Color change or breathing problem
- Stiff or jerky movements
- Lip smacking
- Eye fluttering
- Any other symptoms from the seizure care plan

****Post-Seizure Behaviors:**

- Prompt recovery (seconds)
- Gradual recovery (minutes)
- Slow recovery (confused or needing to sleep)

*****Also complete the Medication Administration Record**