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Directions: Please check (✓) what happens (or happened) during your child's seizure and bring this sheet to your child's neurology appointment.

Description of Spell or Seizure				
Body 	<input type="checkbox"/> whole 	<input type="checkbox"/> right 	<input type="checkbox"/> left 	<input type="checkbox"/> can't tell
Movement 	<input type="checkbox"/> jerking 	<input type="checkbox"/> stiffness 	<input type="checkbox"/> jerking and stiffness 	<input type="checkbox"/> can't tell
Eyes 	<input type="checkbox"/> up ↑ 	<input type="checkbox"/> closed 	<input type="checkbox"/> right → 	<input type="checkbox"/> left ← 
	<input type="checkbox"/> stare 	<input type="checkbox"/> stare and blink 	<input type="checkbox"/> no change 	<input type="checkbox"/> can't tell
Skin Color 	<input type="checkbox"/> blue 	<input type="checkbox"/> no change 	<input type="checkbox"/> can't tell	
Toilet 	<input type="checkbox"/> pee-pee 	<input type="checkbox"/> poop 	<input type="checkbox"/> none	<input type="checkbox"/> can't tell
Mouth 	<input type="checkbox"/> dry 	<input type="checkbox"/> drool 	<input type="checkbox"/> foam 	<input type="checkbox"/> bite tongue 
How Often 	<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly	<input type="checkbox"/> other: _____
After Seizure or Spell				
<input type="checkbox"/> asleep 	<input type="checkbox"/> drowsy 	<input type="checkbox"/> alert 	<input type="checkbox"/> confused 	<input type="checkbox"/> paralyzed 