Client Name:	DESTINY MANAGEMENT SEIZURE REPORT
Record #:	

Date: ___________________

Time Seizure Began: Hour: ________ AM/PM Minute: ________
Time Seizure Ended: Hour: ________ AM/PM Minute: ________

Check symptoms which most closely match symptoms observed:
(Check only the one category that most resembles seizure.)

I.
- ☐ Sudden cry, fall, rigidity
- ☐ Muscle jerks
- ☐ Saliva on lips
- ☐ Rapid breathing
- ☐ Bluish skin
- ☐ Loss of bladder or bowel control

II.
- ☐ A blank stare
- ☐ Rapid blinking
- ☐ Chewing movements of mouth

III.
- ☐ Jerking fingers and toes
- ☐ Awake and aware (Can respond when spoken to)
- ☐ Jerking other limbs

IV.
- ☐ A blank stare
- ☐ Chewing movements of mouth
- ☐ Pulling clothing
- ☐ Dazed, mumbling
- ☐ Unresponsive

Other symptoms observed: ____
____
____

What happened prior to seizure? (activity, location, mood): ______________________
____
____

Comments: ____
____
____

Medical treatment required: **(Please describe, in detail, interventions necessary.)**
☐ First Aid ☐ Medical Facility
____
____

Reported By: ____

Staff Signature/Position Title/Licensure/Degree: ______________________