

**Student Name:** \_\_\_\_\_

*Instructions: Use (1) column for each event. Check off all behaviors that apply.*

DURING SEIZURE	Date / Time	Date / Time	Date / Time	Date / Time	Date / Time
Aware (A) Confused (C)					
Responds to Voice					
Responds to Light Touch					
Not Responsive					
<b>Facial Expressions</b>					
Staring (S) Twitching (T)					
Eyes Rolling (R) Blinking (B)					
<b>Head Movements</b>					
Sudden Head Drop					
Turns to 1-Side					
Turns Side to Side					
<b>Body Stiffens</b>					
Whole Body					
Legs (L) Arms (A)					
<b>Jerking Movements</b>					
Whole Body					
Legs (L) Arms (A)					
<b>Automatic Movements</b>					
Hands Clapping, Rubbing					
Lip Smacking, Chewing					
Walking, Wandering, Running					
<b>Speech</b>					
Able to Talk Normally					
Unable to Talk					
Incoherent					
Nonsense Words					
Wrong Words					
<b>Falls: Yes / No</b>					
Type of Injury					
<b>Incontinent: Yes / No</b>					
<b>AFTER SEIZURE</b>					
Fully Aware (A) Irritable (I)					
Responds Normally					
Confused (C) Tired (T)					
Asleep (A) Agitated (AG)					
<b>**Length of Seizure**</b>					
<b>INTERVENTIONS</b>					
911 (E) VNS Magnet (M)					
Medicine Given					
PCG / MD Notified					
<b>Observer's Initials</b>					
<b>Signature / Title</b>					

## SCHOOL SERVICE FLOW SHEET

Student's Name	School Attending	Hours	Grade																	
<b>SERVICE RENDERED</b>																				
<input type="checkbox"/> 1:1 School Day		<input type="checkbox"/> Transportation Only Complete this section																		
<input type="checkbox"/> 1:1 Field Trip*: Destination:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td rowspan="2" style="width: 5%;">Date</td> <td style="width: 15%;">AM / PM</td> <td style="width: 15%;">AM / PM</td> <td style="width: 15%;">AM / PM</td> <td style="width: 15%;">AM / PM</td> <td style="width: 15%;">AM / PM</td> </tr> <tr> <td>M</td> <td>T</td> <td>W</td> <td>Th</td> <td>F</td> </tr> <tr> <td>Date</td> <td colspan="5">Notes</td> </tr> </table>		Date	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	M	T	W	Th	F	Date	Notes				
Date	AM / PM	AM / PM	AM / PM		AM / PM	AM / PM														
	M	T	W	Th	F															
Date	Notes																			
* Student Report Received (RCV) Report: _____ Time: _____ Initials: _____		* Student Report Given (G) Report: _____ Time: _____ Initials: _____																		
* Medication Received (MCV); Returned (MR) MCV [ ] _____ MR [ ] _____ Name of Medication _____																				
Student is Ambulatory <input type="checkbox"/> OR Student is Wheelchair Bound <input type="checkbox"/>																				
DATE																				
<b>MEDICATIONS GIVEN** v Including PRN's</b>																				
<b>VENTILATION AND THERAPIES</b> N/A <input type="radio"/>																				
Ventilator in Use via Mask or ETT																				
ETT Only      Size																				
Supplemental O2 in use v		@ LPM																		
Spo2 Reading %																				
Cough Assist (CA) Vest Therapy (V) or Nebulizer (N)		Treatment Tolerated v																		
<b>SUCTION</b> N/A <input type="radio"/>																				
Airway Remained Patent																				
VIA: Mouth / Nares / ETT																				
How many Times?																				
<b>SECRETIONS</b> N/A <input type="radio"/>																				
Amount Obtained Scant (Sc); Small (S); Moderate (Mod); Large (L); Copious (C)																				
Consistency Thin (Th); Thick (K); Tenacious (T)																				
<b>**SEIZURE ACTIVITY**</b> N/A <input type="radio"/>																				
Seizure Activity Noted (indicate (+) number of times)																				
*Rescue Medication Given [ ]		Time	Time																	
<b>BLOOD GLUCOSE MONITORING</b> N/A <input type="radio"/>																				
Time / Result																				
Intervention Outcome*																				
<b>NUTRITION</b> N/A <input type="radio"/>																				
Percentage of PO Consumed		(B) Breakfast																		
		(L) Lunch																		
Given Via PEG	Size	Fr.	Amount Given																	
v Tube Flushed	v Tolerated																			
<b>SPLINTS / BRACES: Applied / Removed (A/R)</b> N/A <input type="radio"/>																				
Student Attended: OT / PT / Speech Therapy v																				
Early Dismissal: related to MD Appointment / Illness																				
Administrator / School Nurse / Other School Personnel Printed Name:																				
Licensed Professional Name, Title, and Signature:			RN <input type="checkbox"/> LPN <input type="checkbox"/>																	