








How to Use a Seizure Diary

From home to school, seizures can happen anywhere. This seizure diary is a helpful way to:

- Track how many seizures your child has
- Always have a record to share with your child’s healthcare provider
- See if there are patterns in what triggers your child’s seizures

As your child gets older, you can use this diary to help them get in the habit of tracking their own seizures. In addition to writing down seizures in the diary, you can also take videos or pictures of your child’s seizures to share with their healthcare provider.








Here’s an example of what a **seizure diary** entry might look like:

 Date	 Did you take your medicine today?	 Did a seizure happen today?	 If yes, what type of seizure was it?	 What time did the seizure or seizures start?	 How many seizures were there?	 Were there 2 or more seizures in 24 hours (a seizure cluster)?
06/09/23	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> PARTIAL (FOCAL) <input checked="" type="checkbox"/> GENERALIZED <input type="checkbox"/> OTHER _____	2:00 pm	3	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

SEIZURE DETAILS: For example, was there a trigger to the seizure? How did your child feel before and after the seizure? How long did the seizure last?








SEIZURE DIARY

This seizure diary is an easy way to keep track of your child's seizures and share the information with their healthcare provider. Make sure to bring this seizure diary to your child's healthcare appointments.

 <p>Date</p>	 <p>Did you take your medicine today?</p>	 <p>Did a seizure happen today?</p>	 <p>If yes, what type of seizure was it?</p>	 <p>What time did the seizure or seizures start?</p>	 <p>How many seizures were there?</p>	 <p>Were there 2 or more seizures in 24 hours (a seizure cluster)?</p>
	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> PARTIAL (FOCAL) <input type="radio"/> GENERALIZED <input type="radio"/> OTHER _____ _____			<input type="radio"/> YES <input type="radio"/> NO








SEIZURE DETAILS: For example, was there a trigger to the seizure? How did your child feel before and after the seizure? How long did the seizure last?











 <p>Date</p>	 <p>Did you take your medicine today?</p>	 <p>Did a seizure happen today?</p>	 <p>If yes, what type of seizure was it?</p>	 <p>What time did the seizure or seizures start?</p>	 <p>How many seizures were there?</p>	 <p>Were there 2 or more seizures in 24 hours (a seizure cluster)?</p>
	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> PARTIAL (FOCAL) <input type="radio"/> GENERALIZED <input type="radio"/> OTHER _____ _____			<input type="radio"/> YES <input type="radio"/> NO

SEIZURE DETAILS: For example, was there a trigger to the seizure? How did your child feel before and after the seizure? How long did the seizure last?



						
Date	Did you take your medicine today?	Did a seizure happen today?	If yes, what type of seizure was it?	What time did the seizure or seizures start?	How many seizures were there?	Were there 2 or more seizures in 24 hours (a seizure cluster)?
	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> PARTIAL (FOCAL) <input type="radio"/> GENERALIZED <input type="radio"/> OTHER _____ _____			<input type="radio"/> YES <input type="radio"/> NO

SEIZURE DETAILS: For example, was there a trigger to the seizure? How did your child feel before and after the seizure? How long did the seizure last? 

						
Date	Did you take your medicine today?	Did a seizure happen today?	If yes, what type of seizure was it?	What time did the seizure or seizures start?	How many seizures were there?	Were there 2 or more seizures in 24 hours (a seizure cluster)?
	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> PARTIAL (FOCAL) <input type="radio"/> GENERALIZED <input type="radio"/> OTHER _____ _____			<input type="radio"/> YES <input type="radio"/> NO

SEIZURE DETAILS: For example, was there a trigger to the seizure? How did your child feel before and after the seizure? How long did the seizure last? 