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| **Event Record** |
| This form is to help you collect information about the event(s) causing concern. Show this to your Health Practitioner. |
| Child / Adolescent: |  | Date of Birth: |  |
|  | **Event 1** | **Event 2** |
| **TIP: Capturing future events on video can be helpful for the treating Doctor. Video event only IF child is safe.** |
| Who witnessed the episode? |  |  |
| Date and time of episode? |  |  |
| Did you notice anything before the episode? |  |  |
| What was your child doing just before it started? Did anything appear to trigger the episode? |  |  |
| How did the episode start? |  |  |
| Did you notice any change in your child's breathing or colour? |  |  |
| What happened next?* Was there loss of consciousness?
* Were they able to respond to you?
* Was their body floppy or stiff?
* Did their arms and legs move?
* What did the movements look like?
* Were their eyes open or closed?
* Did their head or eyes jerk or go to one side? Which side?

***Try to note as much other information as you can.*** |  |  |
| How long did the episode last for, and how did you know it had finished? |  |  |
| What was your child like after the episode, e.g., drowsy, sleepy, aggres­sive, etc? |  |  |
| How long was it until your child was back to their usual self? |  |  |
| Any other comments? |  |  |

