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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? | |  |  | | |

