**Event Evaluation Sheet**

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| Observation |  | Detail |
| Date and time |  |  |
| What was the child doing before the onset of the event.eg playing, watching TV, having an angry outburst |  |  |
| Did you notice a change in behaviour or mood before the event. Did the child recall any symptoms before the event eg dizzy, blurred vision, funny taste. |  |  |
| Was there a trigger eg fever, lack of sleep , hunger, upset or excitement. |  |  |
| What was the first thing you noticed? Eg staring, eye movements |  |  |
| Then what happened, describe how things changed as the event went on if this happened.  Did the event affect all limbs was one side more affected than the other.  If there was jerking was this fine tremor like movements of marked big jerks of limbs How responsive was the child to calling their name or to touch. Did you think limbs were stiff or floppy.  How long did the event itself last |  |  |
| Did the child look pale, flushed or a different colour, or have any breathing difficulty |  |  |
| After the event what did the child do. Were they confused or aggressive or sleepy. |  |  |
| How long before they were back to normal. |  |  |
| What did you do during the episode and after eg first aid |  |  |
| Any other comments or things you noticed |  |  |
| Is there a family history of epilepsy or sudden collapse. |  |  |
| Has there been any symptoms brought on by exertion or at night |  |  |
| Are there any difficulties with school work or if preschool any concerns about development. Are there concerns about behaviour |  |  |