



1141 Sunrise Beach Road
Crownsville, MD 21032
410.923.6800
www.HorsesThatHeal.org

Date Received _____
(office use only)

Seizure Statement

Submit to Program Director

A Seizure Statement is required for all clients with any seizure activity in the last 10 Years.

Frequency of seizures varies widely and cannot always be predicted. MTR wants to prepare our horses, staff, and volunteers for correct and safe procedures to ensure client safety in case of a seizure.

Notify your instructor, therapist, or MTR staff person as soon as possible if any changes occur! For clients with seizures – please provide information regarding:

Client Name: _____

Type of seizure: _____

Typical aura/pre-seizure sensations or behaviors during seizure: _____

Typical motor activity during seizure: _____

Average duration of seizure: _____

Current frequency of seizures: _____

Date of last seizure: _____

Description of behavior during the recovery state and its duration: _____

What to do if seizure occurs at center: _____

In my opinion, this client can participate in equine-assisted activities or therapies under appropriate supervision. However, I understand that MTR will determine whether they can safely provide services.

Physician/Parent Name (Print): _____ Signature: _____

Date: _____ Stamp Address Here: _____

Address: _____

City/State/Zip _____

Phone: _____