

Date filled out: \_\_\_\_\_



**ADDITIONAL MEDICAL REPORT FOR SEIZURE DISORDERS**  
**(Only necessary for those with a history of seizures.)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**SEIZURE HISTORY**

Date of last seizure: \_\_\_\_\_ Type of Seizure: \_\_\_\_\_

**Please LIST on the back all of the dates of any seizure activity during the last 5 years.**

Any typical aura or pre-seizure behavior:

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Any typical motor behavior during the seizure:

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Average duration of seizure: \_\_\_\_\_ Current frequency of seizures: \_\_\_\_\_

Typical behavior during recovery from the seizure:

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Seizure medications and their side-effects:

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What to do should a seizure occur at the riding center:

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Additional Comments, and/or concerns:

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I acknowledge the risks and potential for risks of equine related activities. However, I believe and acknowledge that the possible benefits to my son/daughter/ward are greater than the risk assumed.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
(This form must be completed by a parent or legal guardian for persons less than 18 years of age.)