2024

SEIZURE DISCLOSURE

Participant Name: _____ **Date of Birth:** _____

TO BE COMPLETED BY PARTICIPANT'S MEDICAL PERSONNEL:

It is the policy of BraveHearts to consider seizures as either a precautionary condition or a contraindication for participation in services at BraveHearts.

Precaution:

- If the motor activity, change in postural tone, loss of motor control, or alteration in consciousness is minor and is not likely to frighten or injure the horse, participant, volunteers, staff or therapist, then instructor or therapist will make the professional decision on whether or not to continue equine assisted services.
- Seizure medications may cause drowsiness or may cause photo sensitivity (see medication); instructor will make professional decision on whether or not to continue equine assisted services.
- If the horse demonstrates behavioral sensitivity to the seizure activity; then instructor will make professional decision on whether or not to continue equine assisted services.

Contraindication:

- Seizures which result in strong, uncontrollable motor activity or atonic or "drop attack" seizures (due to their sudden and complete loss of postural muscle tone), all equine assisted services will cease until condition is evaluated by a medical personnel.
- If there is a change of frequency or type of seizure, all equine assisted services will cease until the condition is evaluated by medical personnel.
- **The participant's medical personnel must deem it safe for participant to continue participation and indicate it by completing a new Medical Authorization after any seizure activity.**

Type of Seizure: _____

Type of Aura: _____

Typical motor activity during the seizure: _____

Current frequency of _____ Current duration of _____

Are seizures currently being controlled by medications? ☐ YES ☐ NO *If yes, please list:* _____

Describe the participant's behavior during the post-ictal (recovery) state, and its duration: _____

_____

Describe what should be done should a seizure occur at BraveHearts: _____

_____

I, the undersigned, do hereby verify the truth and completeness of all the above disclosures.

*** Medical Personnel's Signature:** _____ **Date:** _____

BraveHearts

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