



Colorado Therapeutic Riding Center, Inc.
 11968 Mineral Road, Longmont, CO 80504
 (303) 652-9131 FAX (303)652-2072 www.ctrcinc.org

Seizure Information

*CTRC strives to provide the safest possible conditions for participants, volunteers and employees. Maintaining a safe environment is a partnership and we need your help. Please take the time to fill out the following information form regarding your or your dependant's, history of seizures. Along with filling out this form, it is very important that CTRC be notified of any changes in health status including any changes in seizure activity. **Notify your instructor or CTRC staff person as soon as possible if any changes occur.** (Please attach sheet or additional information if needed)*

Participant Name: _____ Date: _____

Person filing out form: _____

Type of seizure, please describe: _____

Typical aura (circumstances or warning signs that can bring on seizure): _____

Typical motor activity during seizure: _____

Duration of seizure: _____

Current frequency of seizures: _____

Date of last seizure: _____

Description of post-ictal (recovery) state, and its duration: _____

To be completed by CTRC staff only:

____ A, precautions: _____

____ NA, procedures followed: _____

