Horses for Healing

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name____ Date of Birth__________________

Height______________ Weight__________

Address____

Name of Parent/Guardian ______________________________________

Diagnosis____

Date of Onset______________________________

Past/FutureSurgeries____

Medications:____

***For Persons with Down Syndrome: Negative Cervical X-ray for atlantoaxial instability- X-ray date____________ Negative for clinical symptoms of atlantoaxial instability

Seizure Type____________________________________ Controlled Yes No

Date of last seizure___________________

Shunt Present: Yes No Date of Last Revision: _______________

Tetanus Shot Yes No Date of last Tetanus_____________

Please indicate current or past special needs in the following areas by checking yes or no. If yes, please comment. AREAS Yes No Comments

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			

Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Mobility Independent Ambulation_____ Crutches_____ Braces_____ Wheelchair_____ Walker_____

Please indicate any special precautions/additional information____
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In my opinion, this person can participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review/screening of the person's abilities/limitations by a licensed/credentialed health professional (PT, OT, or Speech) in the implementing of an effective equestrian program.

Treating Physician Name (please print)

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Phone________________________

Treating Physician Signature____Date_____________
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Address____City______________State_________
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