



Participants Medical History Physician's Recommendation

Dear Health Care Provider:

Your patient, _____ (*participant's name*) is interested in participating in our supervised therapeutic horseback riding program. In order to safely provide this service to your patient, we need your recommendation. Please complete the attached Medical History Form.

Date: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y/N Date of Last Seizure: _____

Shunt Present: Y/N Date of last revision: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --

Neurological Symptoms of AtlantoAxial Instability:

Please indicate current or past special needs in the following systems/areas, including surgeries:

Auditory	Y/N	Neurological	Y/N
Visual	Y/N	Muscular	Y/N
Tactile Sensation	Y/N	Balance	Y/N
Speech	Y/N	Orthopedic	Y/N
Cardiac	Y/N	Allergies	Y/N
Circulatory	Y/N	Learning Disabilities	Y/N
Integumentary/Skin	Y/N	Cognitive	Y/N
Immunity	Y/N	Emotional/Psychological	Y/N
Pulmonary	Y/N	Pain	Y/N
Diabetes/Low Sugar	Y/N	Other _____	

Special Precautions/Needs: _____

Please note that the following conditions may suggest precautions and contraindications to equine activities or necessitate extra attention by the instructors. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial Instability - include neurologic
- Symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

Neurological

- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions (i.e. RA, MS)

Medical/Psychological continued

- Fire Setting
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Comprise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control

Other

- Age – Under 4 years
- Indwelling Catheters/Medical Equipment
- Medication – i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

To my knowledge, there is no reason why this person cannot participate in supervised equine activities.

Name/Title: _____

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ License/UPIN Number: _____

With medical approval, the application (Sections 1 & 2) will be reviewed by the therapists/instructors at the Therapeutic Riding Center to ensure we can safely accommodate the Applicant and provide quality services to the individual.