PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant_________________________________DOB_____________Height_________Weight___________

Address____

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___________________________________

Special Precautions/Needs____

____

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

Braces/Assistive Devices____

For those with Down Syndrome: AlantosDens Interval X-rays, Date____________ Result + -

Neurologic Symptoms of Atlanto Axial Instability____

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

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title:____MD DO NP PA Other_________

Signature:____Date ____________________

Address:____

Phone: ( )________________________________ License/UPIN Number:________________________