Mane Stride

An Equine Assisted Therapeutic and Riding Program

Physician's Statement

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and this Physician's Statement form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact our center at the address/phone below.

Orthopedic
Atlantoaxial Instability
Include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/
Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/
Abnormalities

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)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disease

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II
Malformation/Tethered
Cord/ Hydromyelia

Other
Age-under 4 years
Indwelling Catheters
Medical Equipment
Medications i.e.
photosensitivity
Poor Endurance
Skin Breakdown

Physician's Notes _____
_____
_____
_____

Physician's Signature: _____ Date: _____