JAF's THERAPY IN MOTION

5730 Lafayette Rd.
Medina, OH 44256
PH: 216-409-9401
Judy@JafsTherapy.org

Date: _____

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.
(participant's name)

In order to safely provide this service, our center requests that you complete the attached Medical History and 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.

Orthopedic

Atlantoaxial Instability-Include Neurologic Symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

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

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact JAF's Therapy In Motion at the address/phone indicated above.

Sincerely,

Judy Fox,

Director, JAF's Therapy In Motion

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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 *PATH* center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the *PATH* center for ongoing evaluation to determine eligibility for participation.

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Name/Title:_____MD DO NP PA Other_____
Signature:_____Date _____
Address:_____
Phone: ( )_____ License/UPIN Number:_____