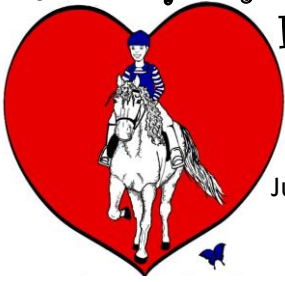


# JAF's THERAPY

## 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**

## 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: Alantodens 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.



Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_