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RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

(This form must be completed annually)

NAME:_____ **BIRTH DATE:** _____
MM / DD / YYYY

ADDRESS: _____
Street City State Zip Code

NAME OF PARENT/GUARDIAN: _____

DIAGNOSIS: _____ **DATE OF ONSET**: _____
MM / DD / YYYY

For Participants with Down Syndrome: Cervical X-ray for Atlantoaxial Instability: Positive _____ Negative _____ X-ray date: _____ MM / DD / YYYY _____ **TETNUS SHOT:** NO___ YES ___ **Last Tetanus shot:** _____ MM / DD / YYYY	**For Participants with seizures:** Seizure Type: _____ Seizure Medication currently being taken: _____ Date of last seizure: _____ MM / DD / YYYY _____ **HEIGHT**: _____ **WEIGHT:** _____	**MOBILITY:** Independent Ambulation NO ___ YES ___ Crutches NO ___ YES ___ Leg Braces NO ___ YES ___ Wheelchair NO ___ YES ___ Additional comments or precautions concerning mobility:

INFORMATION FOR PHYSICIANS

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

MEDICAL/SURGICAL
Allergies
Cancer
Diabetes
Hemophilia
Hypertension
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Serious Heart Condition
Stroke (Cerebrovascular Accident)
Varicose Veins

NEUROLOGIC
Chiari II Malformation
Hydrocephalus/shunt
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders
Spina Bifida
Tethered Cord

ORTHOPEDIC
Atlantoaxial Instabilities
Coxas Arthrosis
Cranial Deficits
Heterotopic Ossification
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Fusion
Spinal Instabilities/Abnormalities
Spinal Orthoses

SECONDARY CONCERNS
Acute exacerbation of chronic disorder
Behavior Problems
Indwelling Catheter
Age two to four years
Age under two years

Continue on to side two of this form ☺

Please indicate if participant has any impairments and/or surgeries in any of the following areas.
If yes, explain in comment area.

AREAS	NO	YES	COMMENTS
Allergies			
Auditory			
Cardiac			
Circulatory			
Cognitive			
Emotional			
Learning Challenges and/or Impairments			
Mental Challenges and/or Impairments			
Muscular			
Neurological			
Orthopedic			
Psychological Challenges and/or Impairments			
Pulmonary			
Speech			
Visual			
Other			

PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. Certified Therapeutic Recreation Specialist (CTRS), Occupational Therapist (OT), Physical Therapist (PT), Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

PHYSICIAN'S NAME (please print):_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____
MM / DD / YYYY

ADDRESS: _____
Street City State Zip Code

PHONE: (**)**_____ **E-MAIL:** _____
Area Code