Serenity Grace Farm
Therapeutic Riding and Driving Center
(919) 302-5503

1292 Pocomoke Road
Franklinton, NC 27525

Participant's Medical History & Physician's Statement

(Must Be Completed by Participant's Physician)

Participant:_____ DOB:_____ M / F Height:_____Weight:_____

Address:_____

Diagnosis:_____Date of Onset:_____

Past/Prospective Surgeries:_____

Medications: _____

_____

Seizure Type:_____Controlled: Y / N Date of Last seizure_____

Changes in frequency and seizure type: Y / N If yes, please Describe:_____

_____

Implanted Vagal Stimulator: Y / N If yes, please Describe:_____

_____

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:_____

Tetanus Shot: Y / N Date:_____

For those with Down Syndrome: AtlantoDens Interval X-rays, Date:_____ Result: + / -

Neurologic Symptoms of AtlantoAxial Instability:_____

Please indicate current or past special needs in the following system/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			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the center will weigh the medical information above again existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title:_____MD DO NP PA Other_____

Signature:_____ Date:_____

Address: _____

Phone (____)_____