MANE STRIDE

An Equine Assisted Therapeutic Riding Program

Participant's Medical History & Physician Statement

Participant: _____ DOB: _____ Ht: _____ Wt: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y or N Date of last seizure: _____
Shunt Present: Y or N Date of last revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation: Y or N Assisted Ambulation: Y or N Wheelchair: Y or N
Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-Rays, Date: _____
Result: + or - 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			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognition			
Emotional			
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 MANE STRIDE will weigh the medical information gives against the existing precautions and contraindications. Therefore, I refer this person to MANE STRIDE for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other
Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____