2024 Preparticipation Physical Evaluation for Healing Hoof Steps & the State of Florida

This completed form must be kept on file by the organization. This form is valid for 365 calendar days from the date of the evaluation.

Healing Hoof Steps Therapeutic Riding Program, 3942 Jace Dr • *Crestview, FL 32539 • (850) 764-1005 • (850) 786-1288 Fax* ● www.healinghoofsteps.org

Part 1. Student Information (to be completed by **student or parent**)

Student's Name:______________________________________Sex: _____ Age: _____ Date of Birth: _____/ _____/_____

School:______________________________Grade in School: Sport(s): ______________________________

Home Address:____Home Phone: (____) _______________

Name of Parent/Guardian:______________________________________E-mail:______________________

Person to Contact in Case of Emergency: ____

Relationship to Student:_______________Home Phone: (_____)__________Work Phone: (_____)__________Cell Phone: (___) __________

Personal/Family Physician:____________________________City/State:__________________Office Phone: (_____) __________

Part 2. Medical History **(to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.**

Question	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	____	____
2. Do you have an ongoing chronic illness?	____	____
3. Have you ever been hospitalized overnight?	____	____
4. Have you ever had surgery?	____	____
5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	____	____
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	____	____
7. Do you have any allergies (for example, pollen, latex, medicine, food, or stinging insects)?	____	____
8. Have you ever had a rash or hives develop during or after exercise?	____	____
9. Have you ever passed out during or after exercise?	____	____
10. Have you ever been dizzy during or after exercise?	____	____
11. Have you ever had chest pain during or after exercise?	____	____
12. Do you get tired more quickly than your friends do during exercise?	____	____
13. Have you ever had racing of your heart or skipped heartbeats?	____	____
14. Have you had high blood pressure or high cholesterol?	____	____
15. Have you ever been told you have a heart murmur?	____	____
16. Has any family member or relative died of heart problems or sudden death before age 50?	____	____
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	____	____
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	____	____
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, or pressure sores)?	____	____
20. Have you ever had a head injury or concussion?	____	____
21. Have you ever been knocked out, become unconscious or lost your memory?	____	____
22. Have you ever had a seizure?	____	____
23. Do you have frequent or severe headaches?	____	____
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	____	____
25. Have you ever had a stinger, burner, or pinched nerve?	____	____
26. Have you ever become ill from exercising in the heat?	____	____
27. Do you cough, wheeze or have trouble breathing during or after activity?	____	____
28. Do you have asthma?	____	____
29. Do you have seasonal allergies that require medical treatment?	____	____
30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)?	____	____
31. Have you had any problems with your eyes or vision?	____	____
32. Do you wear glasses, contacts, or protective eyewear?	____	____
33. Have you ever had a sprain, strain or swelling after injury?	____	____
34. Have you broken or fractured any bones or dislocated any joints?	____	____
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	____	____

If yes, check appropriate blank and explain below:

___ Head	Elbow	Hip
___ Neck	Forearm	Thigh
___ Back	Wrist	Knee
___ Chest	Hand	Shin/Calf
___ Shoulder	Finger	Ankle
___ Upper Arm	Foot	

Question	Yes	No
36. Do you want to weigh more or less than you do now?	____	____
37. Do you lose weight regularly to meet weight requirements for your sport?	____	____
38. Do you feel stressed out?	____	____
39. Have you ever been diagnosed with sickle cell anemia?	____	____
40. Have you ever been diagnosed with having the sickle cell trait?	____	____

FEMALES ONLY (optional

42. When was your first menstrual period? ______________________
43. When was your most recent menstrual period? ________________
44. How much time do you usually have from the start of one period to the start of another?______________________________
45. How many periods have you had in the last year? ______________
46. What was the longest time between periods in the last year? ________

Explain "Yes" answers here:____

____

____

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We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostictests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Parent/Guardian:____Date:_______/_______/ _____

Signature of Student:____Date:_______/_______/_______

Potential Precautions and Contraindications for Equine-Assisted Services

Please note that the following conditions may suggest precautions and/or contraindications to equine assisted services. Therefore, please circle or please note whether these conditions are present and to what degree. The remaining portions of this form will allow for more detail.

Orthopedic Medical/Psychological

Amputation
Atlanto-Axial Instability- includes 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
- Hydromyelia
- Tethered Cord

Medical/Psychological

Medications: i.e., Photosensitivity/Allergies
Animal Abuse
Physical/ Sexual/ Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Setting
Heart Conditions
Hemophilia
Medical Instability
Migraines
Post- Traumatic Stress Disorder
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Indwelling Catheters
Poor Endurance
Skin Breakdown

** **For Persons with Down syndrome**:
Negative Cervical X-ray for Atlantoaxial Instability. ____Yes ____No X-ray Date:__________
Negative for clinical symptoms of Atlantoaxial Instability. ________________________Yes _______No

** **For Persons with Scoliosis**: Degree of Scoliosis: ______________________________________

** **For those with Seizures: Type** ______________________Controlled:______Yes _______No **Date of Last Seizure**:_________________

Tetanus Shot: ____Yes ____No Date: _________________

Medications: ____

____

Mobility	YES	NO
Independent Ambulation		
Walker		
Crutches		
Cane		
Braces		

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Healing Hoof Steps 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 profession (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: ________________________________Physician's Name (Print): ____Date:_______

Address____City__________________State:_____ Zip:__________Phone Number: (____)__________

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Part 3. Physical Examination **(to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).**

Student's Name:______________________________Date of Birth:_____/_____/_____

Height:____________Weight:____________% Body Fat:__________________Pulse:_________Blood Pressure:_____/(____/_____,______/_____)

Temperature:____________Hearing: right: P________F______left: P______F ______

Visual Acuity: Right 20/_______ Left 20/_______ Corrected: Yes No Pupils: Equal_________Unequal __________

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	______	______	______
2. Eyes/Ears/Nose/Throat	______	______	______
3. Lymph Nodes	______	______	______
4. Heart	______	______	______
5. Pulses	______	______	______
6. Lungs	______	______	______
7. Abdomen	______	______	______
8. Genitalia (males only)	______	______	______
9. Skin	______	______	______
MUSCULOSKELETAL			
10. Neck	______	______	______
11. Back	______	______	______
12. Shoulder/Arm	______	______	______
13. Elbow/Forearm	______	______	______
14. Wrist/Hand	______	______	______
15. Hip/Thigh	______	______	______
16. Knee	______	______	______
17. Leg/Ankle	______	______	______
18. Foot	______	______	______

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability:______________________________Diagnosis: ______________________________

____ Precautions: ______________________________

____ Not cleared for:______________________________Reason: ______________________________

____ Cleared after completing evaluation/rehabilitation for: ______________________________

____ Referred to______________________________For: ______________________________

Recommendations: ______________________________

Name of Physician/Physician Assistant/Nurse Practitioner (print):______________________________Date:_____/_____/_______

Address: ______________________________

Signature of Physician/Physician Assistant/Nurse Practitioner ______________________________

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Student's Name: ____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: ______________________________ Diagnosis: ______________________________

____

____ Precautions: ____

____

____ Not cleared for: ______________________________ Reason: ______________________

____ Cleared after completing evaluation/rehabilitation for: ______________________________

Recommendations: ____

Name of Physician (print): ______________________________ Date: ____/____/____

Address: ____

Signature of Physician: ____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.