HEALING HOOF STEPS
Rider's Medical History and Physician's Statement

Name:_____ Date of Birth: _____

Address: _____

City:_____ State:_____ Zip:_____

Name of Parent or Guardian: _____

Diagnosis: _____

Date of Onset: _____Height _____ Weight _____

** **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: _____

Seizure 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 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 profession (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: _____

Physician's Name (Please Print): _____ Date: _____
Address: _____ City:_____
State: _____ Zip: _____ Phone Number: (_____) _____