SPECIAL TROOPERS ADAPTIVE RIDING SCHOOL
33148 K22—Sioux City, IA 51108—www.scstars.org—P: 712.239.5042—F: 712.224.3471

PHYSICIAN'S AUTHORIZATION & PARTICIPANT'S MEDICAL HISTORY

To be completed by Physician. Please fill out completely.

STARS, Inc. is a therapeutic/adaptive horseback riding program designed to benefit the participants physically, socially, and emotionally. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information prior to riding in the program.

PARTICIPANT NAME: _____ Age: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of onset: _____

Medications: _____

Height: _____ Weight: _____ (Required to Participate.)

Allergies: _____

Seizure Type: _____ Controlled: Yes ☐ No ☐ Date of Last Seizure: _____

Shunt Present: Yes ☐ No ☐ Special Precautions/Needs: _____

Mobility: Independent ☐ Crutches ☐ Cane ☐ Braces ☐ Walker ☐ Wheel Chair ☐

Persons with Down Syndrome - Atlantoaxial Instability: Positive ☐ or Negative ☐ Date of X-Ray: _____

Please indicate problems and/or surgeries in any of the following areas. If yes, please comment.

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Learning Disability			
Cognitive			
Psychological			
Other			

It is my opinion, this participant can receive therapeutic/adaptive horseback riding under the appropriate supervision at Special Troopers Adaptive Riding School, (STARS, Inc.) and understand that STARS, Inc. will determine whether they can safely provide services to this participant.

Physician's Signature: _____ Date: _____

Physician's printed name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____