Date: ____________________________

Your patient, ________________________________ is interested in participating in therapeutic equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician’s Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**
- Atlantoaxial Instability – include neurological symptoms
- Coxarthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

**Medical/Psychological**
- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions (e.g., RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

**Neurologic**
- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II Malformation/
- Tethered Cord/Hydromyelia

**Other**
- Age – usually under 4 years
- Indwelling Catheters/medical equipment
- Medications, i.e., photosensitivity
- Poor Endurance
- Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Sarah McKay
Executive Director
MEDICAL HISTORY AND PHYSICIAN’S STATEMENT FORM

Participant: ___________________________ DOB: _______ Height: _____ Weight: ______

Address: ________________________________________________________________

Diagnosis: ________________________________ Date of Onset: _________________

Past/Prospective Surgeries: __________________________________________________

Medications: ________________________________

______________________________________________________________________________

IMPORTANT NOTE TO DOCTOR OR MEDICAL FACILITY:
COMPLETE THE 2 PAGES

If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed, and dated and your form is stapled to our form.

To my knowledge, there is no reason why this person cannot participate in therapeutic 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 referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

**FOR PERSONS WITH DOWN SYNDROME:

Neurologic symptoms of Atlantoaxial instability:

☐ Present

☐ Not Present

Name/Title: ___________________________________________________________________

Signature: ___________________________________________________________________ Date: ________________________________

Address: _____________________________________________________________________

Phone: ______________________________________________________________________

License/UPIN Number: ______________________________________________________

** Continue to page two to complete student medical history.
**CONTINUED**

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Please indicate current or past history in the following systems/areas, including surgeries:

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