PARTICIPANT PHYSICIAN STATEMENT

Dear Health Care Provider:

Your patient, _____________________________________, is interested in participating in supervised equine 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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**
- Atlantoaxial Instability – include neurologic symptoms
- Coxa Arthritis
- 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 (i.e. RA, MS)
- Fire Setting
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorder
- Weight Control

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

**Other**
- Age – 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 equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Lauren Kochakian, Assistant Program Director

lauren@upreachtec.org

REVISED 09/2017   LK
# Participant’s Medical History and Physician’s Statement

Participant: ______________________________________
DOB: ____/_____/_____
Height: ______
Weight: ______

Address: __________________________________________________________________________________________________

Diagnosis: __________________________________________________________________

Date of Onset: _____/_____/_____

Past/Prospective Surgeries: 

Medications: ____________________________________________________________________________________

Seizure Type: _____________________________________

Controlled: ___ YES  ___  NO

Date of Last Seizure: _____/_____/_____

Shunt Present: ___ YES  ___  NO

Date of last revision: _____/_____/_____

Special Precautions/Needs:

<table>
<thead>
<tr>
<th>Mobility: Independent Ambulation: ___ YES  ___  NO</th>
<th>Assisted Ambulation: ___ YES  ___  NO</th>
<th>Wheelchair: ___ YES  ___  NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Braces/Assistive Devices: ________________________</td>
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</tbody>
</table>

For those with Down Syndrome:

AtlantoDens Interval X-rays, date: _____/_____/_____

Result: _____+  _____--

Neurologic Symptoms of AtlantoAxial Instability:

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

<table>
<thead>
<tr>
<th>Auditory</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Visual</td>
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<tr>
<td>Tactile Sensation</td>
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<td>Speech</td>
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<td>Cardiac</td>
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<td>Circulatory</td>
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<td>Immunity</td>
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<tr>
<td>Pulmonary</td>
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<td>Neurologic</td>
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<td>Muscular</td>
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<td>Learning Disability</td>
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<td>Emotional/Psychological</td>
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<td>Pain</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities. I understand that UpReach Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to UpReach Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Name/Title: ______________________________________________

MD  DO  NP  PA  Other

Signature: ________________________________________________

Date: ______/_____/_____

Address: __________________________________________________

Phone: ________________________________

License/UPIN Number: ________________________________

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