Dear Physician:

Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant’s name) is interested in participating in supervised adaptive/therapeutic riding sessions.

In order to safely provide this service, our operating center requests that you complete/update the attached Medical History and Physician’s Statement Form and Release. **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 Neurologic**

Atlantoaxial instability-include neurologic symptoms Hydrocephalus/Shunt

Coxa arthrosis Seizure

Cranial deficits Spina Bifida/Chiari II

Heterotopic ossification/Myositis ossificans malformation/Tethered

Joint subluxation/dislocation cord/Hydromyelia

Osteoporosis

Pathologic Fractures

Spinal fusion/Fixation

Spinal instability/Abnormalities

**Other**

Age-under four years Indwelling catheters

Medications (i.e. Photosensitivity) Poor endurance

Skin breakdown Medical/Psychological

Allergies Animal abuse

Physical/Sexual/Emotional abuse Blood pressure control

Dangerous to self or others Exacerbations of medical

Fire settings conditions

Hearing conditions Hemophilia

Medical instability Migraines

PVD Respiratory compromise

Recent surgeries Substance abuse

Thought control disorders Weight control disorder

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 operating center at the address/phone/e-mail indicated above.

Sincerely,

Katie Oakland

Executive Director

**RIDER’S MEDICAL HISTORY AND PHYSICIAN’S STATEMENT**

*To be completed by Physician. Please fill out completely.*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_ Tetanus Shot (circle) Y / N Date of last Tetanus shot\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Controlled (circle) Y / N Date of last seizure\_\_\_\_\_\_\_\_\_ Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\*\*\*\*\*\*\*\*For persons with Down Syndrome:\*\*\*\*\*\*\*\*\*\**

Cervical X-ray for Atlantoaxial Instability \_\_\_\_\_\_Positive \_\_\_\_\_\_Negative X-ray date\_\_\_\_\_\_\_\_\_\_\_\_

Annual Complete Neurological Exam Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 |  |  |  |
| Allergies |  |  |  |
| Learning Disability |  |  |  |
| Mental Impairment |  |  |  |
| Psychological Impairment |  |  |  |
| Other |  |  |  |

**Mobility:** Independent Ambulation: Y / N Crutches: Y / N Braces: Y / N Wheelchair: Y / N

Please indicate any special precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Statement: To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. **(See accompanying letter for precautions and contraindications.)**

**This client has my permission to participate in TR 4 Heart and Soul Therapeutic Horseback Riding &/or Hippotherapy program(s) under appropriate supervision.**

**This release is valid for the period of: (please circle one) 1 year 2 years**

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print or stamp:

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_

Zip\_\_\_\_\_\_\_\_