Rider's Medical History, Physician's Statement, and Contraindications

Please give to your doctor to complete and sign.

Please complete all sections. **It is important that you print legibly**.

Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

Height (in feet &/or inches) _____ Weight (in lbs) _____

- ***For persons with Down Syndrome:***
  - ***Negative on neurological exam for any decrease in neurological function or of any symptoms consistent with Atlantoaxial Instability. Exam date:*** _____

Shunt: ❑Yes ❑No

Seizures: ❑Yes ❑No If Yes: Type: _____ Controlled? _____

Date of last seizure: _____

Medications:_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: ❑Yes ❑No

If "no": Wheelchair: ❑Yes ❑No Walker: ❑Yes ❑No

Braces/AFOs: ❑Yes ❑No

Please indicate any additional pertinent medical information:

_____

_____

Precautions/Contraindications

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore; when completing this form, please note whether these conditions are present, and to what degree.

Scale of 1-5: 1 = Minor, 3 = Moderate, 5 = Severe

Orthopedic

___ Spinal Fusion
___ Atlanto-axial Instabilities
___ Kyphosis
___ Hip Subluxation & Dislocation
___ Pathologic Fractures
___ Heterotopic Ossification
___ Cranial Deficits
___ Internal Spinal Stabilization Devises
___ Spinal Instabilities/Abnormalities
___ Scoliosis
___ Lordosis
___ Osteoporosis
___ Coxas Arthosis
___ Osteogenesis Imperfecta
___ Spinal Orthoses

Medical/Surgical

___ Allergies
___ Poor Endurance
___ Diabetes
___ Varicose Veins
___ Hypertension
___ Stroke (Cerebrovascular Accident)
___ Cancer
___ Recent Surgery
___ Peripheral Vascular Disease
___ Hemophilia
___ Serious Heart Condition

Precautions/Contraindications, continued

Neurologic

___ Hydrocephalus/shunt
___ Tethered Cord
___ Hydromyelia
___ Seizure Disorders
___ Spina Bifida
___ Chiari II Malformation
___ Paralysis due to Spinal Cord injury

Secondary Concerns

___ Behavioral problems
___ Indwelling catheter
___ Acute exacerbation of chronic disorder
___ Incidents of Aggression
___ Age under four years

Additional requirement for Down Syndrome diagnosis

1) A medical exam with special reference to neurological function.

2) Certification from a physician that an exam did not reveal atlanto-axial instability or focal neurological disorder. Please attach proof of certification to this form.

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that as a PATH Intl. Center, Helen Woodward Animal Center's Therapeutic Riding Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Physician Name (**please print**):

_____

Physician Signature:

_____

Address: _____ City: _____

State: _____ Zip: _____

Phone Number: _____