

Physician's Medical Form for Participation in Equestrian Activities

Client's Name _____ Birthdate _____ Height _____ Weight _____
 Client's Address _____ Phone _____ Cell _____
 Diagnosis _____ Date of Onset _____
 Past/Prospective Surgeries _____
 Medications _____
 Shunt Present NO YES – Date of last revision _____
 Seizures NO YES – Seizure type _____ Date of last seizure _____
 Down's Synd. NO YES – AtlantoDens Interval X-ray date _____ Result + -
 Neurologic Symptoms of AtlantoAxial Instability if present _____
 Mobility (please circle) Independent/Assisted Ambulation/Wheelchair/OTHER _____
 Braces/ Assistive Devices _____

Please note that the following conditions in the table below may suggest precautions and contraindications to therapy using a horse. Therefore, please circle any conditions that are present and to what degree:

<p>ORTHOPEDIC Atlantoaxial Instability (include neurologic symptoms) Coxa Arthrosis Cranial Deficits Heterotopic Ossification/ Myositis Ossificans Joint subluxation/ dislocation Osteoporosis Pathologic Fractures Spinal Fusion/ Fixation Spinal Instability/ Abnormalities</p>	<p>MEDICAL/ PSYCHOLOGICAL Allergies Animal Abuse Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to self or others Exacerbations of medical conditions Fire Setting Heart Conditions Hemophilia Medical Instability Migraines PVD Respiratory Compromise Recent Surgeries Substance Abuse Thought Control Disorders Weight Control Disorders</p>
<p>NEUROLOGIC Hydrocephalus/ Shunt Seizure Spina Bifida/ Chiari II Malformation Tethered Cord/ Hydromyelia</p>	<p>OTHER Age – under 3 years Indwelling Catheters Medications – (i.e. photosensitivity) Poor Endurance Skin Breakdown</p>

Special Precautions/Needs _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand the therapist and/or instructor will weigh the medical information above against existing precautions and contraindications. I refer this person with the understanding of ongoing evaluation to determine eligibility for participation. I concur with a review of this person's abilities/ limitations by a licensed/credentialed health professional in the implementation of an effective equine activity program.

Physician Name _____ MD DO Other _____ License/UPIN Number _____
 Signature _____ Date _____ Phone _____
 Address _____ City _____ State _____ Zip _____