

# Rider's Medical History and Physician's Statement to be completed annually

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	Name:	Date of Birth:						
Diagnosis:	Address:							
"For Persons with Down Syndrome:    Negative Cervical X-Ray for Atlantoaxial Instability. X-ray date:								
Negative Cervical X-Ray for Atlantoaxial Instability. X-ray date:	Diagnosis:	gnosis: Date of Onset:						
Negative for clinical symptoms of Atlantoaxial Instability.   Tetanus Shot:	**For Persons with Down Syn	drome:						
Tetanus Shot:	☐ Negative Cervical X-	Ray for At	tlantoaxial	Instability. X-ray date:	· · · · · · · · · · · · · · · · · · ·			
Seizure Type	☐ Negative for clinical	symptoms	of Atlanto	paxial Instability.				
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	Tetanus Shot: ☐ Yes	☐ No	Date	e: Height:	\	Neight:		
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	Seizure Type	ControlledDate of last seizure						
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	Medications							
Auditory  Visual  Speech  Cardiac  Circulatory  Pulmonary  Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation   Yes   No   Crutches   Yes   No   Braces   Yes   No   Wheelchair   Yes   No   Please indicate any special precautions:  To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.  Physician Name (please print)  Physician Signature  Address   City   State   Zip	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.							
Visual  Speech  Cardiac  Circulatory  Pulmonary  Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation	Areas	Yes	No	Comments				
Speech Cardiac Circulatory Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other  Mobility: Independent Ambulation	Auditory							
Cardiac  Circulatory  Pulmonary  Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation	Visual							
Circulatory Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other  Mobility: Independent Ambulation	Speech							
Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other  Mobility: Independent Ambulation   Yes   No   Crutches   Yes   No   Braces   Yes   No   Wheelchair   Yes   No   Please indicate any special precautions:  To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program. Physician Name (please print) Physician Signature Address	Cardiac							
Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation   Yes   No   Crutches   Yes   No   Braces   Yes   No   Wheelchair   Yes   No   Please indicate any special precautions:  To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.  Physician Name (please print)  Physician Signature  Address City State Zip	Circulatory							
Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other  Mobility: Independent Ambulation	Pulmonary							
Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation	Neurological							
Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation								
Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation	<u> </u>							
Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation								
Psychological Impairment Other  Mobility: Independent Ambulation								
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Physician Signature City State Zip	understand that the therapeutic and contradictions. I concur wit sional (e.g. PT, OT, Speech, Psy	riding cent h a review o chologist, e	er will weig of this pers tc.) in the i	h the medical information above agon's abilities/limitations by a licens mplementing of an effective equest	gainst the esed/credent	existing precautions tialed health profes-		
Address City State Zip						<del> </del>		
					 State	Zip		

# **Information for Physician**

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

### **Orthopedic**

Spinal Fusion

Spinal Instabilities/Abnormalities

Atlantoaxial Instabilities

**Scoliosis** 

**Kyphosis** 

Lordosis

Hip Subluxation and Dislocation

Osteoporosis

Pathologic Fractures

Coxas Arthrosis

**Heterotopic Ossification** 

Osteogenesis Imperfecta

**Cranial Deficits** 

Spinal Orthoses

Internal Spinal Stabilization Devices

## **Neurologic**

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

#### Medical/Surgical

Allergies

Cancer

Poor Endurance

**Recent Surgery** 

Diabetes

Peripheral Vascular Disease

Varicose Veins

Hemophilia

Hypertension

**Serious Heart Condition** 

Stroke (Cerebrovascular Accident)

#### **Secondary Concerns**

Behavior Problems
Age Under Two Years
Age Two - Four Years
Acute exacerbation of chronic disorder
Indwelling catheter