PHYSICIAN CONSENT FORM
THERAPEUTIC HORSEMANSHIP

Dear Health Care Provider:

Your patient, ____________________________________ , is interested in participating in therapeutic horsemanship activities. Some conditions, if present, may represent precautions or contraindications to therapeutic riding and/or off horse therapeutic horsemanship activities. In order to safely provide this service, please complete this form.

Individuals with Down Syndrome must have a negative cervical spine x-ray in order to ride.
Down Syndrome: (circle) Yes No If Yes, date of cervical spine x-ray:___________ Result:______________

Please circle any of the conditions listed below that are present.

Orthopedic
Atlantoaxial Instability
Coxa Arhrosis
Cranial Deficits
Heterotopic Ossification / Myositis Ossificans
Joint subluxation / dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion / fixation
Spinal Joint Instability / Abnormalities

Neurologic
Hydrocephalus / Shunt
Seizure
Spina Bifida / Arnold Chiari II Malformation

Other
Indwelling Catheters / Medical Equipment
Medications, i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical / Psychological
Allergies
Animal Abuse
Anxiety
Cardiac Condition
Depression
Physical / Sexual / Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise

Please indicate your level of consent by checking one of the following statements. Any considerations regarding the health of your patient while participating in a ConnEQtions, Inc program will be addressed in our plans.

Please check one:

☐ ________________________ is medically cleared to participate in therapeutic riding. Considerations ______________
____

☐ ________________________ is medically cleared to participate in off-horse therapeutic horsemanship activities, but may **not** ride a horse. Considerations ____
____

☐ ________________________ is not medically cleared to participate in any therapeutic horse related activities due to __
____

____ ________________________________
Signature of Physician Date