Dear Healthcare Provider:

A child in your care has expressed a desire to participate in adaptive horseback riding. Please complete the Health Care Provider Statement, or provide a similar statement of your own, indicating whether or not you feel this child is medically able to safely participate in activities on or around equines and any potential concerns you may have regarding your patient's participation in equine activities. Please note that the conditions listed below may suggest precautions and contraindications to equine activities. When completing this form, please specifically note whether these conditions are present, and to what degree.

**Orthopedic**

Atlantoaxial Instability- include neurologic symptoms

Coxarthritis

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/Chiari II Malformation/Tethered   
 cord/Hydromyelia

Other

Age-under 3 years

Indwelling Catheters/Medical Equipment

Medications- e.g., photosensitivity

Poor Endurance

Skin Breakdown

Medical/Psychological

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

**Exacerbations of Medical Conditions**

Fire Setting

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Dangerous to Self or Others

Thank you for your assistance. If you have any questions or concerns regarding this patient’s participation in equine-assisted activities, please feel free to contact us at (480) 359-6470 or at admin@manesandmiraclesaz.org

Thank you,

Manes and Miracles

**Health Care Provider Statement**

To Whom It May Concern,

\*(Name of Patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been seen in our office for medical and/or psychiatric diagnosis and/or treatment.

At the request of the parent or guardian of the child, (Print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I am providing the following information:

The patient's current diagnoses are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Patient weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertaining to the diagnoses for which this patient is seen in our office, and in light of the specific precautions and contraindications listed on the Manes and Miracles Healthcare Provider Letter, I have the following cautions, concerns, or limitations to advise regarding the patient's participation in equine-assisted activities both on the ground or mounted:

The above information is true and accurate to the best of my knowledge. It is my opinion that this patient is medically fit to receive, and may benefit from, adaptive horseback riding lessons provided under proper instruction and under the limitations set forth above, if any.

**\***Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\***Date: \_\_\_\_/\_\_\_\_/\_\_\_\_   
  
**\*Indicates Required Field**