Rider's Medical History and Physician's Statement – Page 1 of 2

To be completed annually

Name:_____ Date of Birth: _____

Rider's Height_____ Weight _____

Address:_____

Name of Parent/Guardian: _____

Diagnoses:_____ **Date of Onset:** _____

****For persons with Down Syndrome:**

_____Negative Cervical X-Ray for Atlantoaxial Instability Date of X-Ray: _____

_____Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: □ Yes □ No Date: _____

Seizures □ Yes □ No Controlled_____ Date of last seizure _____

Medications_____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please indicate if conditions are present or if the patient has had surgeries in any of the following areas by checking yes or no. **If yes, please comment.**

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Hydrocephalus/shunt			
Spina Bifida			
Tethered Cord			
Chiari II Malformation			
Hydromyelia			
Paralysis due to Spinal Cord Injury			
Seizure Disorders			
Muscular			
Orthopedic			
Spinal Fusion			
Spinal Instabilities/ Abnormalities			
Scoliosis			
Kyphosis			
Lordosis			
Hip Subluxation and Dislocation			
Osteoporosis			
Pathologic Fractures			
Coxas Athrosis			
Heterotopic Ossification			
Osteogenesis Imperfecta			

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Cranial Deficits			
Spinal Orthoses			
Internal Spinal Stabilization Devices			
Allergies			
Allergy to Bee Sting			
Allergy to Medication			
Diabetes			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Psychiatric Diagnoses			
Medical/Surgical			
Cancer			
Poor Endurance			
Recent Surgery			
Diabetes			
Peripheral Vascular Disease			
Varicose Veins			
Hemophilia			
Hypertension			
Serious Heart Condition			
Stroke (Cerebra-vascular Accident)			
Secondary Concerns			
Behavior problems			
Age under two years			
Age 2-4 years			
Acute exacerbation of chronic disorder			
Indwelling catheter			
Other			

Mobility: Independent Ambulation_____Crutches_____Braces _____
Wheelchair _____Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the riding center will weigh the medical information above against the existing precautions and contraindications. 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's Printed Name:_____

Physician's Signature: _____

Address_____City_____State_____Zip _____

Telephone number: (_____) _____ Date:_____