STRIDES OF STRENGTH
THERAPEUTIC RIDING
2717 Gaston Farm Rd.
Chester, SC 29706
803-374-6255

Physicians Release

Date: ___________________________
Dear Health Care Provider:
Your patient, __________________________________
(participant's name)
is interested in participating in supervised equine activities with Strides of Strength Therapeutic Riding programs (SOS). In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Our organization's staff are certified, and the center is accredited to provide equine assisted activities and therapies. Strides of Strength provides adaptive equipment, wheelchair access, and assistance where needed, to offer services in the safest manner possible. The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing the below form, please circle whether these conditions are present and, if so, to what degree.

ORTHOPEDIC

Spinal Fusion

Spinal Instabilities/Abnormalities Atlantoaxial

Instabilities

Scoliosis

Kyphosis

Lordosis

Hip Subluxation and Dislocation Osteoporosis

Pathologic Fractures

Coxarthrosis

Heterotopic Ossification Osteogenesis Imperfecta

Cranial Deficits

Internal Spinal Stabilization Disease

Spinal Orthoses

NEUROLOGIC

Hydrocephalus/shunt

Spina bifida

Tethered Cord

Chiari Malformation

Hydromyelia

Paralysis due to Spinal Cord Injury

Seizure Disorders

MEDICAL / SURGICAL

Cancer

Poor Endurance

Recent Surgery

Diabetes

Peripheral Vascular Disease

Varicose Veins

Hemophilia

Hypertension

Serious Heart Condition

Stroke (Cerebrovascular Accident) Allergies

SECONDARY CONCERNS

Behavior Problems

Age under 2 years

Age 2 - 4 years

Acute exacerbation of Chronic disorder

Indwelling catheter

Participant's Medical History & Physician's Statement
(to be completed by a licensed physician)

Please fill this out to its fullest extent:
Participant: ___________________________ DOB: _________ Height: ________ Weight: ________
Address: ____
Diagnosis: ____ Date of Onset: _______________
Past/Prospective Surgeries: ____
Medications: ____
Seizure Type: __________________________ Controlled: Y N Date of Last Seizure: ______________
Shunt Present: Y N Date of last revision: ____
Special Precautions/Needs: ____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: ____
For those with Down Syndrome: AtlantoDens Interval X-rays, date: __________________ Result: + --
Neurologic Symptoms of AtlantoAxial Instability: ___present ___absent _______% of incident

	Yes	**No**	**Comments:**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Digestion			
Elimination			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Behavioral			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Strides of Strength Therapeutic Riding's staff will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the organization for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA Other __________
Signature: ____ Date: ______________________
Address: ____
Phone: (____) _____________________________ License/UPIN Number: _____________________________