SUNRISE INC.
MEDICAL FORM

1052 Gurney Dr., Richmond, IN 47374 (765) 983-1500 www.Sunrisetrc.com

Must be completed by a physician's office

Date: _____

Dear medical provider; your patient is interested in participating in supervised equine activities. In order to provide this service our center requires a medical history and signed physician's statement for each participant. Please note that the listed consitions may suggest precautions and contraindications to equine actiities. When completing this form please note whether these conditions are present, and to what degree. If you have questions or concerns regarding this patient's participation in therapeutic horsemanship and equine related activities, please do not hesitate to contact the center using the phone number above. Thank you!

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Weight: _____ Height: _____

Parent / Guardian Name: _____

Parent / Guardian Phone: _____ Alternate Phone: _____

Circle One	Medical Condition	Physician Details	Circle One	Medical Condition	Physician Details
Y N	Spinal Joint Conditions (scoliosis, lordosis, kyphosis, instabilities or other abnormalities)		Y N	Diabetes	
Y N	Joint subluxations / dislocations		Y N	PVD / Circulatory Disorders	
Y N	Osteoporosis / Arthritis		Y N	Blood Pressure Disorders	
Y N	Pathologic Fractures		Y N	Poor Endurance	
Y N	Coxasarthrosis		Y N	Pulmonary Conditions	
Y N	Heterotopic Ossification		Y N	Medical Instability (please explain)	
Y N	Osteogenesis Imperfecta		Y N	Migraines	
Y N	Cranial Deficits		Y N	Hemophilia	
Y N	Hydrocephalus / Shunt		Y N	Cardiac Conditions (please explain)	
Y N	Spinal Cord Conditions (spina bifida, SCI, chiari II malformation, hydromyelia, tethered cord)			**Mental Health**	
Y N	Seizure Disorders (please provide what type, and when last seizure occurred)		Y N	Behavior Problems	
Y N	Allergies (environmental)		Y N	Weight Control Disorder	
Y N	Recent Surgeries (please explain)		Y N	Impulse Control Disorder	
Y N	Cancer		Y N	Substance Abuse	
Y N	Skin Integrity Issues		Y N	Danger to Self or Others	
Y N	Multiple Sclerosis		Y N	Animal Abuse (history of or current)	
Y N	Any indwelling medical devices?		Y N	Physical / Sexual / Emotional Abuse	
Y N	Stroke / CVA		Y N	Fire Setting	

Other? _____

FOR PERSONS WITH DOWN SYNDROME

Does the participant have symptoms of Atlantoaxial Instability? _____

Has the participant had an X-ray or CT scan to confirm diagnosis? _____ Date the test was performed: _____

What were the results? _____

PHYSICIAN'S STATEMENT

Given the diagnosis and medical information, this person is not medically precluded from participant in equine assisted activities. I understand that Sunrise Inc. will weigh the medical information given against existing precautions and contraindications. Therefore, I refer this person to Sunrise Inc. for ongoing evaluation to determine eligibility for participation.

Physician's Name / Title (please print): _____

License / UPIN Number: _____ ◯MD ◯DO ◯NP ◯PA ◯Other_____

Address: Phone:

Physician Signature: _____ Date: _____