

2026 Preparticipation Physical Evaluation for Healing Hoof Steps & the State of Florida

This completed form must be kept on file by the organization. This form is valid for 365 calendar days from the date of the evaluation.
Healing Hoof Steps Therapeutic Riding Program, 3942 Jace Dr • Crestview, FL 32539 • (850) 764-1005 • (850) 786-1288 Fax • www.healinghoofsteps.org

Part 1. Student Information (to be completed by student or parent)

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____
 Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below. Circle questions you don't know answers to.

- | | Yes | No | | Yes | No |
|---|-----|-----|--|---------|-----------|
| 1. Have you had a medical illness or injury since your last check up or sports physical? | ___ | ___ | 26. Have you ever become ill from exercising in the heat? | ___ | ___ |
| 2. Do you have an ongoing chronic illness? | ___ | ___ | 27. Do you cough, wheeze or have trouble breathing during or after activity? | ___ | ___ |
| 3. Have you ever been hospitalized overnight? | ___ | ___ | 28. Do you have asthma? | ___ | ___ |
| 4. Have you ever had surgery? | ___ | ___ | 29. Do you have seasonal allergies that require medical treatment? | ___ | ___ |
| 5. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler? | ___ | ___ | 30. Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? | ___ | ___ |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance? | ___ | ___ | 31. Have you had any problems with your eyes or vision? | ___ | ___ |
| 7. Do you have any allergies (for example, pollen, latex, medicine, food, or stinging insects)? | ___ | ___ | 32. Do you wear glasses, contacts, or protective eyewear? | ___ | ___ |
| 8. Have you ever had a rash or hives develop during or after exercise? | ___ | ___ | 33. Have you ever had a sprain, strain or swelling after injury? | ___ | ___ |
| 9. Have you ever passed out during or after exercise? | ___ | ___ | 34. Have you broken or fractured any bones or dislocated any joints? | ___ | ___ |
| 10. Have you ever been dizzy during or after exercise? | ___ | ___ | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | ___ | ___ |
| 11. Have you ever had chest pain during or after exercise? | ___ | ___ | <i>If yes, check appropriate blank and explain below:</i> | | |
| 12. Do you get tired more quickly than your friends do during exercise? | ___ | ___ | ___ Head | Elbow | Hip |
| 13. Have you ever had racing of your heart or skipped heartbeats? | ___ | ___ | ___ Neck | Forearm | Thigh |
| 14. Have you had high blood pressure or high cholesterol? | ___ | ___ | ___ Back | Wrist | Knee |
| 15. Have you ever been told you have a heart murmur? | ___ | ___ | ___ Chest | Hand | Shin/Calf |
| 16. Has any family member or relative died of heart problems or sudden death before age 50? | ___ | ___ | ___ Shoulder | Finger | Ankle |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? | ___ | ___ | ___ Upper Arm | Foot | |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems? | ___ | ___ | 36. Do you want to weigh more or less than you do now? | ___ | ___ |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, or pressure sores)? | ___ | ___ | 37. Do you lose weight regularly to meet weight requirements for your sport? | ___ | ___ |
| 20. Have you ever had a head injury or concussion? | ___ | ___ | 38. Do you feel stressed out? | ___ | ___ |
| 21. Have you ever been knocked out, become unconscious or lost your memory? | ___ | ___ | 39. Have you ever been diagnosed with sickle cell anemia? | ___ | ___ |
| 22. Have you ever had a seizure? | ___ | ___ | 40. Have you ever been diagnosed with having the sickle cell trait? | ___ | ___ |
| 23. Do you have frequent or severe headaches? | ___ | ___ | | | |
| 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | ___ | ___ | | | |
| 25. Have you ever had a stinger, burner, or pinched nerve? | ___ | ___ | | | |

FEMALES ONLY (optional)

42. When was your first menstrual period? _____
 43. When was your most recent menstrual period? _____
 44. How much time do you usually have from the start of one period to the start of another? _____
 45. How many periods have you had in the last year? _____
 46. What was the longest time between periods in the last year? _____

Explain "Yes" answers here: _____

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We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Parent/Guardian: _____ Date: ____/____/____
Signature of Student: _____ Date: ____/____/____

Potential Precautions and Contraindications for Equine-Assisted Services

Please note that the following conditions may suggest precautions and/or contraindications to equine assisted services. Therefore, please circle or please note whether these conditions are present and to what degree. The remaining portions of this form will allow for more detail.

Orthopedic Medical/Psychological

- Amputation
- Atlanto-Axial Instability- includes neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/ Myositis Ossificans
- Joint Subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion/Fixation
- Spinal Instability/ Abnormalities

Neurologic

- Hydrocephalus/ Shunt
- Seizure
- Spina Bifida:
 - Chiari II Malformation
 - Hydromyelia
 - Tethered Cord

Medical/Psychological

- Medications: i.e., Photosensitivity/Allergies
- Animal Abuse
- Physical/ Sexual/ Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Fire Setting
- Heart Conditions
- Hemophilia
- Medical Instability
- Migraines
- Post- Traumatic Stress Disorder
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorder
- Indwelling Catheters
- Poor Endurance
- Skin Breakdown

**** For Persons with Down syndrome:**

Negative Cervical X-ray for Atlantoaxial Instability. ____ Yes ____ No X-ray Date: _____
Negative for clinical symptoms of Atlantoaxial Instability. _____ Yes _____ No

**** For Persons with Scoliosis:** Degree of Scoliosis: _____

**** For those with Seizures:** Type _____ Controlled: ____ Yes ____ No Date of Last Seizure: _____

Tetanus Shot: ____ Yes ____ No Date: _____

Medications: _____

Mobility	YES	NO
Independent Ambulation		
Walker		
Crutches		
Cane		
Braces		

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Healing Hoof Steps 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 profession (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: _____ Physician's Name (Print): _____ Date: _____
Address _____ City _____ State: _____ Zip: _____ Phone Number: (____) _____

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Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____
 Height: _____ Weight: _____ % Body Fat: _____ Pulse: _____ Blood Pressure: ____/(____/____, ____/____)
 Temperature: _____ Hearing: right: P _____ F _____ left: P _____ F _____

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
MUSCULOSKELETAL			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation
 ____ Disability: _____ Diagnosis: _____

____ Precautions: _____

____ Not cleared for: _____ Reason: _____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

Recommendations: _____

Name of Physician/Physician Assistant/Nurse Practitioner (print): _____ Date: ____/____/____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner _____

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Student's Name: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

___ Cleared without limitation

___ Disability: _____ Diagnosis: _____

___ Precautions: _____

___ Not cleared for: _____ Reason: _____

___ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician (print): _____ Date: ___ / ___ / ___

Address: _____

Signature of Physician: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.