PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Participant Name: _____

DOB: _____ **Height:** _____ **Weight:** _____

Address: _____

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

_____

Medications: _____

_____

Seizure Type (if app): _____ Controlled? Y N

Date of last Seizure: _____

Shunt present? Y N

Date of last Revision: _____

Special precautions/Needs (if app): _____

_____

_____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive devices: _____

For those with Down Syndrome: Neurological symptoms of Atlantoaxial Instability □ Present □ Absent

Please describe the applicant's abilities or limited abilities in the following areas:

(include assistance required or equipment needed)

- Physical Function: (i.e., mobility skills such as transfers, walking, wheelchair use, driving, bus riding, etc.)

  _____

  _____

  _____

- Psycho/social Function: (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fear/concerns, etc.)

  _____

  _____

  _____

- Goals: (i.e., Why are you applying for participation? What would you like to accomplish?)

  _____

  _____

  _____

- Other Information:

  _____

  _____

  _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities or therapies. I understand that the PATH International Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other_____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number:_____