Participant's Medical History and Physician's Statement

Reins of Hope is an adaptive horseback riding program designed to benefit the participants physically, socially, and emotionally. Safety equipment and specially tested horses and volunteers are used in each program. In order to ensure the fullest possible protection and greatest personal benefit from the program, *every participant is required to furnish the following medical information before being accepted as a participating riding student.*

Evaluation Date: _____

Participant Name				*Date of Birth*		*Age*	
Height		*Weight*		*Head Circumference*		*Parent/Guardian Phone #*	
Name of Parent/Guardian(s)							
Address		*City:*		*State*		*Zip Code*	
Diagnosis				*Date of Onset*			
Past/Future Surgical Procedures							

Please indicate current or past areas of concern / special needs, including surgeries. *If Yes, please comment. They may have precautions and contraindications to equine activities.*

Area of Concern	***Yes***	***No***	***Comments***
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional / Psychological			
Pain			

Participant's Medical History and Physician's Statement

For ALL participants with Down Syndrome: Due to the nature of Equine-Assisted Activities (horseback riding) we require that ALL participants diagnosed with Down Syndrome must have an ANNUAL certification from their physician that a neurological and/or physical examination reveals no sign of AAI or decrease in neurological function:
☐ ***Negative Cervical X-Ray for atlantoaxial instability.*** ***X-Ray Date:*** _____
☐ ***Negative for clinical symptoms of atlantoaxial instability***

SEIZURE INFORMATION			
Has the participant experienced a Seizure in the Past?			
☐ Yes, please indicate seizure type		*Type:*	☐ No
Are the seizures controlled?	☐ Yes	☐ No	Date of Last Seizure:

Current Medications: _____

_____

_____

Are braces or other assistive devices used? (Please circle)
Crutches Walker Wheelchair Braces AFOs G-Tube Communication Device
Other - please list:

_____

Please indicate any Precautions / Needs not noted above: _____

_____

_____

In my opinion, this individual can participate in supervised equine-assisted services / adaptive horseback riding instruction. Yes / No

Physician's Name (please print): _____ **Phone**: _____
Physician's Signature: _____ **Date**: _____
Address: _____ **City**: _____ **State**: ____ **ZipCode**: _____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact us at 712-485-4221.