BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

This form must be completed and signed by the participant's physician or referring licensed medical professional.

RIDERS MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Rider Name:____DOB: ____________________
Required to match to a horse: **Height: _____Weight: ________Body shape: Apple___Pear___Stringbean___**
Address: ____
Primary Diagnosis: ____________________________________Date of Onset: __________________________
Secondary Diagnosis: __________________________________Date of Onset: __________________________
Shunt Present: Yes Date of last revision: ____
Mobility: Independent Ambulation Assisted Ambulation Wheelchair
Braces/Assistive Devices: ____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date_________________Result: + -
Neurologic Symptoms of AtlantoAxial Instability: ____
Please indicate current or past special needs in the following system/areas, including surgeries:

	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			
Other			

Additional Physician Instructions noted on reverse side of this form: _____YES _____NO

Physician's Statement
Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the Baraboo River Equine-Assisted Therapies, Inc., will weigh the medical information given against the existing precautions and determine eligibility for participation.
Name/Title____MD DO NP PA Other_____________
Signature:____Date_________________
Address:____
Phone:____License/UPIN Number____________________