

**HOPE REINS AT MARCODY RANCH
3804 PIONEER TRAIL
NEW SMYRNA BEACH, FL 32168
(386) 424-0123**

Rider's Medical History and Physician's Release –Must be completed by Physician

Name: _____ DOB: _____ Height: _____ Weight _____

Address: _____

Name of [] Parent or [] Guardian: _____

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis _____ Date of Onset: _____

Tertiary Diagnosis _____ Date of Onset _____

Shunt Present: Y N Date of Last Revision: _____ Tetanus shot: Y/N: Date if Yes _____

Seizure Type: _____ Controlled: Y N Date of last seizure: _____

PLEASE LIST ALL CURRENT MEDICATIONS:

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____

Any contagious diseases: _____

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility: Independent Ambulation: Yes _____ No _____ Crutches: Yes _____ No _____
Wheelchair: Yes _____ No _____ Braces: Yes _____ No _____

Past/Prospective Surgeries: _____

Special Precautions/Needs: _____

Physician's signature required on page 2

Physician Information

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		Medical/ Surgical	
Spinal Fusion		Allergies	
Spinal Instabilities/ Abnormalities		Cancer	
Internal Spinal Stabilization Devices		Poor Endurance	
Atlantoaxial Instabilities		Recent Surgery	
Scoliosis		Diabetes	
Kyphosis		Peripheral Vascular Disease	
Lordosis		Varicose Veins	
Hip Subluxation and Dislocation		Hemophilia	
Osteoporosis		Hypertension	
Pathologic Fractures		Serious Heart Condition	
Coxas Arthrosis		Stroke (Cerebrovascular Accident)	
Heterotopic Ossification			
Osteogenesis Imperfecta			
Cranial Deficits			
Spinal Orthoses		Neurologic	
		Seizure disorders	
		Hydrocephalus/shunt	
Secondary Concerns		Spina Bifida	
Behavior problems		Tethered Cord	
Age two - four years		Chiari II Malformation	
Acute exacerbation of chronic disorder		Hydromyelia	
Indwelling catheter		Paralysis due to Spinal Cord Injury	
Integumentary/Skin			

Riders with Down Syndrome: PLEASE NOTE:

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

- a) Most recent cervical x-ray for AAI: [] Positive [] Negative.....Date of X-ray _____
- b) Annual cervical exam for AAI: [] Positive [] Negative.....Date of X-ray _____

Physician Verification--Please PRINT your name, sign & date--THANK YOU

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Physician Name/Title: (please print) _____

Signature: _____ Date: _____ Phone: _____

Address: _____

Additional Comments: _____