INSPIRED ACRES

Participant Medical History and Physician's Statement

Must be signed by Physician and Client/Parent/Guardian

Client Name: _____M/F: _____Date of Birth_____ Height _____ Weight _____
Diagnosis_____ Date of Onset_____
Seizure Type_____ Controlled_____ Date of last seizure_____
Medications_____
Shunt Present: Yes No Date of last shunt revision: _____
Past/Prospective surgeries: _____
Please indicate if the patient has a problem and/or surgeries in the following areas by checking Yes or No. If yes, please comment.

Areas	Yes	No	Comments
Behavioral			
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning			
Psychological			
Other			

Mobility: Independent Ambulation: Y. N Crutches: Y N Braces: Y N Wheelchair: Y. N

Client/Parent/Guardian Signature: _____ Date: _____

*****PHYSICIAN MUST SIGN AND DATE THIS FORM BELOW*****

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that INSPIRED ACRES will weigh the medical information above against the existing precautions and contraindications. Therefore, I refer this person to INSPIRED ACRES for ongoing evaluation to determine eligibility for participation. I have read the attached Precautions and Contraindications.

**** FOR PERSONS WITH DOWN SYNDROME: Neurologic symptoms of Atlanto Axial Instability.** Present Absent
Please indicate any special precautions: _____

►Physician Signature _____ **◄ Date** _____

Physician Name (please print) _____ **MD, DO, NP, PA Other** _____

NPI: _____ **Phone:** _____