Horse Connections, Inc.
Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____

Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____
_____

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

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 systems/areas, including surgeries:

Y	N	Comments
		Auditory
		Visual
		Tactile Sensation
		Speech
		Cardiac
		Circulatory
		Integumentary/Skin
		Immunity
		Pulmonary
		Neurologic
		Muscular
		Balance
		Orthopedic
		Allergies
		Learning Disability
		Cognitive
		Emotional/Psychological
		Pain
		Other

9/00

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the therapeutic riding center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the therapeutic riding center for ongoing evaluation to determine eligibility for participation.

I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( )_____ License/UPIN Number: _____