

Seaside Therapeutic Riding Inc.

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____

Address: _____ Weight: _____

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 difficulties 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 | | | |

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Seaside Therapeutic Riding r will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g. PT, OT SPEECH, PSYCHOLOGIST, ETC) in the implementations of an effective equestrian program

Name/Title: _____ MD DO Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number _____