PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant Name________________________________ 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: ____

Neurologic Symptoms of Atlanto Axial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

			Comments
Auditory:	Y	N	________________
Visual:	Y	N	________________
Tactile Sensation:	Y	N	________________
Speech:	Y	N	________________
Cardiac:	Y	N	________________
Circulatory:	Y	N	________________
Integumentary/Skin:	Y	N	________________
Immunity:	Y	N	________________

			Comments
Pulmonary:	Y	N	______________________________
Neurologic:	Y	N	______________________________
Muscular:	Y	N	______________________________
Balance:	Y	N	______________________________
Orthopedic:	Y	N	______________________________
Allergies:	Y	N	______________________________
Learning Disability:	Y	N	______________________________
Cognitive:	Y	N	______________________________
Pain:	Y	N	______________________________
Emotional/Psychological:	Y	N	______________________________

Other:____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that EQUI-KIDS Therapeutic Riding Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to EQUI-KIDS for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA Other __________

Signature: ____ Date: ____________________

Address: ____

Phone: (______) __________________________ License/UPIN Number: __________________________