Calvin Center
Therapeutic Riding Program

Rider's Medical History and Physician's Statement

To be completed by applicant's physician. Please type or print. Use black or blue ink.

Applicant's Name _____ Date of Birth _____ Gender _____

Parent / Guardian _____

Address _____

City _____ State _____ Zip _____

Diagnosis _____ Age of onset _____

Height _____ Weight _____

Please list current and past special needs in the following areas by checking YES or NO. If YES, please include complete information, including surgical history, pertaining to the situation. Attach an additional page if needed.

SPECIAL NEED	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
Auditory Impairment			
Attention Deficit / Hyperactivity			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses / Contacts:
Allergies			Type of Reaction
Cardiac			
Circulatory			
Gastrointestinal Gastrostomy			
Pulmonary Asthma / COPD			
Neurological Hydrocephalus/ Shunt			
Balance Impairment			

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Sensory Loss			
Hypertonicity			
Hypotonicity			
Urological			
Incontinence			
Indwelling Catheter			
Muscular Contractures			
Skeletal Spinal Column Injury			
Subluxing or Dislocating Joints			
Laminectomy			
Spinal Fusion			
Scoliosis – Degree / Type / Brace / Last X-Ray			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Fractures			Location? Healed?
Other			

For Persons with Down Syndrome:

Cervical X-ray for Atlantoaxial Instability:

Positive _____ Negative _____ X-Ray Date_____

Current clinical exam on _____(date)

reveals _____ *no symptoms* of Atlantoaxial Instability.

Comments:

_____

_____

_____

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Medications: (type, purpose, dose):

_____

_____

_____

Seizure Type: _____

Controlled _____

Date of Last Seizure _____

Comments _____

_____

Mobility Status:

Ambulatory: _____yes_____no

Assistive Device: _____cane _____crutches _____walker

Prosthetic/Orthotics: _____yes _____no

If yes, please specify _____

Please indicate special precautions: _____

_____

IN MY OPINION, THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE SIGNED.

Physician's Signature _____

Date_____

Physician's Name (Please Print) _____

UPIN or License # _____

Physician's Address _____

City _____ State_____ Zip _____

Physician's Telephone Number _____

****Only signatures of MD's or DO's are accepted****

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INFORMATION FOR PHYSICIANS

The following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic

- Atlantoaxial or other cervical instability – including neurologic symptoms
- Activity limiting arthritis Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans (activity limiting)
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion/Fixation
- Spinal Instability/Abnormalities

Medical/Psychological

- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

Neurologic

- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II
- Malformation/Tethered Cord/Hydromyelia

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Other

- Age – under 4 years'
- Indwelling Catheters
- Medications - photosensitivity, balance,memory, dizziness, judgement
- Poor endurance
- Skin Breakdown