



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 | | | |

| | | | |
|--|--|--|-------------------|
| 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:



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****



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



Other

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