Rider's Medical History and Physician's Statement - 2017

Name:_____ **DOB:**_____

Address:_____

Name of Parent/Guardian:_____

Diagnosis:_____

Date of onset:_____

HorseSense For Special Riders is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a rider.

***FOR PERSONS WITH DOWN SYNDROME*:**

_____ Negative Cervical X-ray for Atlantoaxial Instability _____ Date of X-ray

_____ Negative for clinical symptoms of Atlantoaxial Instability

Basic Information:

Height:_____ **Weight:**_____

Seizure Type:_____ **Controlled:**_____

Date of last seizure:_____

Medications:

_____

_____

_____

Please Indicate if patient has a problem and/or surgeries In any of the following areas by checking yes or no, If yes, please comment.

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Others			

Mobility

	Yes	**No**
Independent Ambulation		
Crutches		
Braces		

Wheelchair		

Please indicate any special precautions:

_____
_____
_____
_____
_____

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Spinal Fusion
Spinal Instabilities / Abnormalities Atlantoaxial
Scoliosis
Kyphosis Lordosis
Hip Subluxation & Dislocation Osteoporosis Pathologic Fractures Coxas Arthrosis Heterotopic Ossification Osteogenesis Imperfecta Cranial Deficits
Spinal Orthoses

NEUROLOGIC

Hydrocephalus / Shunt Spina Bifida Tethered Cord
Chiari II Malformation Hydromyelia Paralysis due to Spinal Cord injury
Seizure Disorders

MEDICAL/SURGICAL

Allergies Cancer
Poor Endurance Recent Surgery Diabetes
Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension
Serious Heart Condition Stroke (Cerebrovascular Accident)

SECONDARY CONCERNS

Behavior problems

Age under two years Age two - four years Acute exacerbation of chronic disorder Indwelling catheter

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Physician Name (please print):_____ Date:_____

Physician signature:_____ Phone Number:_____

Address:_____ City:_____

State:_____ Zip Code:_____