Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

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"Wish It, Dream It, Do It!"

Date: _____

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached (please see reverse) Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and/or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability – include neurological symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans	Blood Pressure Control
Joint Subluxation/Dislocation	Dangerous to self or others
Osteoporosis	Exacerbations of medical condition(s)
Pathological Fractures	Fire Settings
Spinal Fusion/Fixation	Heart Conditions
Spinal Instability/Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus/Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorders
Age – usually under 4 years	Weight Control Disorders
Indwelling Catheters	
Medications, i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone number indicated above.

Sincerely,

Kristin E. Mason, Program Director ***(Please complete information on other side)***

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: _____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, Diets/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: + --**
Neurological Symptoms of AtlantoAxial Instability: _____
_____May participate in all activities; _____May participate except for: _____

This participant/patient is up-to-date on all the following routine childhood immunizations:

	Y	N	Date:
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

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			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed & dated and your form is stapled to our form.

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 referral of the patient to a licensed/credentialed health professional (e.g. PT, OT, SLT, Psychologist, etc) in the implementations of an effective equestrian program.

Name/Title: _____ MD DO Other: _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____