For Physician to Complete

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: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

_____ May participate in all activities _____ May participate except for: _____

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			
Neuroligic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Balance			
Pain			
Other			

Please Complete Page Two on Back

This participant is up-to-date on the following routine childhood immunizations.

	Y	N	Date
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diptheria			
Other			

For the Physician's Office: 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 to implement an effective equestrian program.

Name/ Title: _____

Signature: _____

Address: _____

Phone: _____ License/UPINNumber: _____