Health Directed Riding, Inc.

Where Rehab Reins

Participant's Medical History & Physicians Statement

Participant's Medical History and Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Primary Diagosis: _____ 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 / needs: _____

Mobility: Independent Ambulation: **Y** **N** Assisted Ambulation: **Y** **N** Wheel Chair: **Y** **N**

Braces / Assistive Devices:

For those with Down Syndrome: AtlantoDens Interval X-rays: Date: Result: **+** **-**

Neurologic Sympltomes of AtlantoAxial Istability: _____

Pleasie indicate current or past difficulties in the following systems / areas, including allergies:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Lerning Disability			
Cognitive			
Emotional / Psychological			
Pain			
Other			

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 the review of this person's abilities/limitations by a licensed / credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name / Title: _____ **MD** **DO** **NP** **PA** **Other**

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN number: _____