Rider's Medical History and Physician's Statement

Please give to your doctor to complete and sign.

Please complete all sections

Name: ____________________________________ Date of Birth:_______________________

Address:____

Name of Parent/Guardian:____

Diagnosis:_______________________________________ Date of Onset:_________________

Height______ Weight_______

- ***For persons with Down Syndrome:***
  - ❑ ***Negative Cervical X-ray for Atlantoaxial Instability. X-ray date_________________***
  - ❑ ***Negative for clinical symptoms of Atlantoaxial Instability***

Tetnus Shot: ❑Yes ❑No Date________

Shunt: ❑Yes ❑No

Seizures: 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.

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

Mobility: Independent Ambulation ❑Yes ❑No Crutches ❑Yes ❑No Braces ❑Yes ❑No

Wheelchair ❑Yes ❑No Please indicate any special precautions:______________________

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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 health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) ____

Physician Signature____

Address___________________________ City____________________ State________ Zip_________