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## Participant's Medical History & Physician's Statements

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications (type, purpose, dose): \_\_\_\_\_

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** Wheelchair **Y N**

Braces/Assisted Devices: \_\_\_\_\_

If Downs Syndrome, Atlanto-Axial Subluxation? **Y N** Result: Positive \_\_\_ Negative \_\_\_

Neurologic Symptoms of Atlanto-Axial Subluxation Instability: \_\_\_\_\_

Tetanus Shot: **Y N** Date: \_\_\_\_\_

Please indicate if the client has or has a history of the following secondary problems by checking yes or no. If "yes" please include **COMPLETE** information pertaining to the problem.

	Yes	No	If "Yes", or History Describe
Auditory Impairment			
Cognitive Impairment			
Learning Disability			
Mental Impairment			

Speech Impairment			
Emotional/Psychological			
Allergies			
Immunity			
Integumentary/Skin			
Cardiac			
Tactile Sensation			
Balance			
<b>Circulatory</b>			
➤ PVD			
➤ Postural Hypotension			
➤ Hemophilia			
<b>Pulmonary</b>			
➤ Asthma/COPD			
<b>Neurological</b>			
➤ Seizures Controlled: <b>Y</b> <b>N</b>			Type: _____ Last Seizure: __/__/__
➤ Hydrocephalus			
➤ Head Injury			Date of Injury: __/__/__
➤ Shunt			
➤ Sensory Loss			
➤ Pain			
<b>Muscular</b>			
➤ Contractures			
<b>Skeletal</b>			
➤ Spinal Column Injury			
➤ Subluxing Joints			

➤ Dislocating Joints			
➤ Laminectomy/Fusion			
➤ Scoliosis Last X-Ray ___/___/___/			Degree/Type/Brace
➤ Kyphosis/Lordosis			Degree/Type
➤ Spondylolisthesis			
➤ Spinal Abnormality			
➤ Osteoporosis			
➤ Heterotrophis Ossification			
➤ Joint Disease			
➤ Cranial Defects			
➤ Fractures			Location: _____ Healed: _____
➤ Other			

### Medical History

Please indicate any medical problems not indicated above.

Please indicate special precautions:

#### Medical:

#### Some contraindications for Horseback Riding

1. Persons with Herrington Rod
2. 30 degree scoliosis
3. Acute Arthritis (rheumatiod)
4. Unstable Altantoaxial Dislocation
5. Severe Osteoporsis
6. Spinal Cord Paralysis above Thoracic
7. Spondylothesis
8. Prolapsed Inter Vertebral Disc
9. Subluxation or Dislocation of Hip
10. Haemophilia

### Mobility Status

Ambulatory: **Y** **N**

Can the student ambulate independently: **Y** **N**

If "No", describe: \_\_\_\_\_

### Prosthetics/Orthodontics

Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

Please indicate any other additional information that might help us work with this student. Thank you for your time!

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

Name/Title:(Print) \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

For I CAN-T.E.R. Office Only      Date Received: \_\_\_\_\_

Start Date of Rider: \_\_\_\_\_