ROCKING HORSE RANCH

Therapeutic Riding Program

(252) 752-0153 www.rhrnc.com

PARTICIPANT'S MEDICAL HISTORY & MEDICAL PROVIDER STATEMENT

Name: _____ Date of Birth: _____

Address: _____

Name of Parent/Guardian: _____ Telephone: _____

Height: _____ Weight: _____ Tetanus Shot: YES (include date): _____ NO

Diagnosis: _____ Date of Onset: _____

Medication(s): _____

Medical History: _____

_____

Surgical History (include dates): _____

Mobility: Independent Ambulation: YES NO Assisted Ambulation: YES NO Wheelchair: YES NO

Assistive Devices/Orthotics: _____

Seizure Activity: YES NO If YES, Type: _____ Controlled: YES NO

Date of Last Seizure: _____ *NOTE: If seizure activity has occurred on the last 6 months, additional information and documentation is required. Please contact the barn office for additional instructions.

The remaining sections are to be completed by the participant's Medical Provider:

Atlantoaxial Instability (AAI) – The Professional Association of Therapeutic Horsemanship International (PATH) requires that prior to starting mounted activities, participants with Down Syndrome will have:

1. A yearly medical examination including a complete neurologic exam that shows no evidence of AAI.
2. Certification by a physician that an examination did not reveal atlantoaxial instability or focal neurologic disorder.

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Please indicate **current or past special needs** in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	YES	NO	COMMENTS
Auditory			
Visual			
Tactile Stimulation			
Speech			
Integumentary/Skin			
Immunity			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Balance			
Muscular			
Orthopedic			
Allergies			
Cognition			
Mental Impairment			
Emotional/Psychological			
Pain			
Other:			

Additional Comments: _____

_____

_____

_____

_____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Lordosis
Hip Subluxation and Dislocation
Hip or Knee Arthritis
Osteoporosis
Pathologic Fractures
Heterotropic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthosis
Internal Spinal Stabilization Device

Neurologic
Hydrocephalus/Shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Autonomic Dysfunction
Seizure Disorders

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Cerebrovascular Accident

Other:
Behavior Problems
Acute Exacerbation of Chronic Disorder
Indwelling Catheter
Internal Pumps
Ostomy/Colostomy
PEG or G-Tube

Please indicate any special precautions: _____

This patient has my permission to participate in a horseback riding program and/or in other equine-assisted activities under appropriate supervision. To my knowledge, there is no reason why this patient cannot participate in supervised equine-assisted activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications, and also consider their ability to structure a safe program for this patient. Therefore, I refer this person to Rocking Horse Ranch Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Physician Name (please print): _____

Address: _____Telephone: _____

Physician Signature: _____ Date: _____