Dear Physician:

Your patient, _____ (client's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our operating center requests that you complete/update the attached Medical History and Physician's Statement Form and Release. **Please note that the following conditions *may* suggest precautions and contraindications to therapeutic horseback riding.** Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial instability-include neurologic symptoms
Coxa arthrosis
Cranial deficits
Heterotopic ossification/Myositis ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal fusion/Fixation
Spinal instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered cord/Hydromyelia

Other

Age-under four years
Medications (i.e. Photosensitivity)
Skin breakdown
Allergies
Physical/Sexual/Emotional abuse
Dangerous to self or others
Fire settings
Hearing conditions
Medical instability
PVD
Recent surgeries
Thought control disorders
Indwelling catheters
Poor endurance
Medical/Psychological
Animal abuse
Blood pressure control
Exacerbation of medical conditions
Hemophilia
Migraines
Respiratory compromise
Substance abuse
Weight control disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address/phone/email indicated above.

Sincerely,
Head Instructor
HorsePower, Inc.

RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

*To be completed by the rider's Primary Physician. Please fill out **completely**.*

Name _____ D.O.B. _____

Age_____ Height_____ **Weight**_____

Tetanus Shot (circle) Y / N Date of last Tetanus shot_____

Diagnosis _____ Date of Onset _____

Seizure type _____ Controlled: Y / N Date of last seizure_____

Medications_____

**********For persons with Down Syndrome:**********

Cervical X-ray for Atlantoaxial Instability _____Positive _____Negative X-ray Date_____

**********For persons with Autism:**********

DSM-5 ASD Level of severity: Level 1_____ Level 2 _____ Level 3 _____

Please indicate problems and/or surgeries in any of the following areas. If *yes*, please comment.

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: Y / N Crutches: Y / N Braces: Y / N Wheelchair: Y / N

Please indicate any special precautions: _____

_____

Physician's Statement: To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. **(See accompanying letter for precautions and contraindications.)**

This client has my permission to participate in HorsePower's Therapeutic Riding program(s) under appropriate supervision. Recommended Frequency: (One hour/1x/week is standard) _____

This release is valid for the period of: (please circle one) 1 year 2 years 3 years

Physician Signature_____ Date_____

Please print or stamp:
Physician Name_____ Phone (_____) _____

Address _____City_____State_____Zip_____