HORSEPOWER
THERAPEUTIC RIDING

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Participant Medical History & Physician's Statement

Must be completed and signed by a physician prior to the onset of lessons and then annually by Jan 1st

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____ Gender: _____
Primary and Secondary Diagnoses: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y_____N_____ Date of Last Seizure:_____
Shunt Present: Y _____ N _____ Date of last revision: _____
Medications that impact bone density: _____ Braces/Assistive Devices: _____
Mobility: Independent Ambulation Y_____N____ Assisted Ambulation Y____ N____ Wheelchair Y____N____
Special Precautions: _____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities. Yes or No MUST be checked for each.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac / Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Medications Impacting Bone Density			
Seizures			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that HorsePower will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to HorsePower Therapeutic Riding for ongoing evaluation by HorsePower to determine eligibility for participation.

Medical Physician Name: _____ License No: _____

Signature: _____ Date: _____

Address: _____ Phone: _____