

Appalachian Therapeutic Riding Center
Participant's Medical History & Physician's Statement

Participant _____ DOB _____ Height _____ Weight _____

Address _____
Street/ PO Box City State Zip

Diagnosis _____ Date of Onset _____

Past / Prospective Surgeries _____

Medications _____

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 / Assistive devices : _____

For those with **Down Syndrome** (see attached info) AtlantoDens Interval Xrays, date _____ Result + -

Neurological Symptoms of AtlantoAxial Instability _____

Please indicate current or past difficulties in the following systems / areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

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.

Name / Title _____ MD DO NP PA Other _____

Signature _____ Date _____

Address _____

Phone _____ License/UPIN number _____