

Participant's Medical History and Physician's Statement

To be completed by Physician

Participant: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: (Street) _____ (city) _____ (St.) _____ (Zip) _____

Diagnosis: _____ Date of Onset: _____

Current Medications: _____

For: _____

Past/Prospective Surgeries: _____

Shunt Present: Y N Date of last revision: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: Yes No Assisted Ambulation: Yes No Wheelchair: Yes No

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --

Neurologic Symptoms of AtlantoAxial Instability:

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

Areas	Yes	No	Comments
Auditory			
Visual			Vision without correction: Vision corrected to:
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Asthma			
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 NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ License/UPIN #: _____ Date: _____ Phone: (____) _____