



Participant Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 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: AtlantoDens Interval X-rays, date: _____ Result: + -
 Neurological Symptoms of AtlantoAxial Instability: _____

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

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

Given the above diagnosis and medical information, this person is not medically precluded from participant in equine assisted activities. I understand that the Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation, and for ongoing participation.
 Name/Title: _____ MD DO NP PA Other: _____
 Signature: _____ Date: _____
 Address: _____
 Phone: _____ License/UPIN Number: _____

Date				
Initials				