ADAPTIVE HORSMANSHIP & RIDING PHYSICIAN STATEMENT 2024

PHYSICIANS STATEMENT & RIDER'S MEDICAL HISTORY (PAGE 1)

(ALL SECTIONS MUST BE COMPLETED *IN FULL* BY THE PHYSICIAN ANNUALLY)

Name _____ **Date of Birth** _____

Address _____

Name of Parent/Guardian _____

Diagnosis _____

Date of Onset _____

FOR PERSONS WITH DOWN SYNDROME: Neurological symptoms of Atlantoaxial Instability:
Present_____ **Absent**_____
Tetanus Shot Yes No **Date** _____
Height _____ **Weight** _____
Seizure Type _____ **Controlled** _____ **Date of Last Seizure** _____
Seizure Warning Signs _____
Medications _____
_____

Please indicate if patient has a problem and /or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Continued on next page

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PHYSICIAN'S RELEASE (page 2)

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic/adaptive horseback riding. When completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

NEUROLOGIC
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation

NEUROLOGIC (cont.)
Hydromyelia
Paralysis due to Spinal Cord injury
Seizure Disorders

MEDICAL/SURGICAL
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

SECONDARY CONCERNS
Behavior Problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

MOBILITY

Independent Ambulation Yes No **Crutches** Yes No **Braces** Yes No **Wheelchair** Yes No

Please indicate any special precautions _____

_____

_____

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PHYSICIAN'S RELEASE (page 3)

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic/adaptive riding 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, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Physician name (please print)

_____

Physician Signature

_____

Address _____

City_____ **State** _____ **Zip** _____

Phone (____)_____**DATE** _____