Date: _____

Dear Health Care Provider: _____

Your Patient (*participant's name*) _____ is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note the following conditions may suggest precautions and contraindications to equine activites. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instablitily - include neurologic symptoms
Coxarthrosis
Crainial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/ Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activites, please feel free to contact Special Strides at the address/phone indicated above.

Sincerely,

Special Strides

Participant's Medical History & Physican's Statement

Form to be filled out by a medical professional

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 Precations/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: + -

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			
Congitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activites and/or therapies. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindictions. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA other

Signature: _____ Date: _____

Address: _____

Phone: License/UPIN Number: