

Special Equestrians

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Rider's Medical History and Physician's Release –Must be completed by Physician

Name: _____ Date of Birth: _____

Address: _____

Name of Parent / Guardian: _____

Diagnosis: _____ Date of Onset: _____

Height: _____ Weight: _____ Tetanus shot: Yes: _____ No: _____

Seizure Type: _____ Controlled: _____ Date of last seizure: _____

Medications: _____

Any contagious diseases: _____

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

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

Mobility: Independent Ambulation: Yes _____ No _____ Crutches: Yes _____ No _____
 Wheelchair: Yes _____ No _____ Braces: Yes _____ No _____

Please Indicate any special precautions:

Physician Information

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify if any of the following conditions are present and to what degree.

<u>Orthopedic</u>	Yes	No	<u>Medical/ Surgical</u>	Yes	No
Spinal Fusion			Allergies		
Spinal Instabilities/ Abnormalities			Cancer		
Atlantoaxial Instabilities			Poor Endurance		
Scoliosis			Recent Surgery		
Kyphosis			Diabetes		
Lordosis			Peripheral Vascular Disease		
Hip Subluxation and Dislocation			Varicose Veins		
Osteoporosis			Hemophilia		
Pathologic Fractures			Hypertension		
Coxas Arthrosis			Serious Heart Condition		
Heterotopic Ossification			Stroke (Cerebrovascular Accident)		
Osteogenesis Imperfecta			<u>Muscular</u>		
Cranial Deficits			Hypotonic		
Spinal Orthoses			Hypertonic		
Internal Spinal Stabilization Devices			Trunk Control, Upper/Lower extremity, please specify		
Fractures			<u>Neurologic</u>		
			Seizure disorders		
<u>Secondary Concerns</u>			Hydrocephalus/shunt		
Behavior problems			Spina Bifida		
Age under two years			Tethered Cord		
Age two - four years			Chiari II Malformation		
Acute exacerbation of chronic disorder			Hydromyelia		
Indwelling catheter			Paralysis due to Spinal Cord injury		

****If student has Down Syndrome, an additional Atlantoaxial Dislocation X-ray form is required.****

If yes was checked for Scoliosis, Kyphosis, Lordosis, Please List the Degree and the date of last X-Ray Below

Scoliosis: Degree _____ Last X-Ray Date _____

Kyphosis: Degree _____ Last X-Ray Date _____

Lordosis: Degree _____ Last X-Ray Date _____

Further comments / Notes:

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications.

Printed Name: _____ MD DO NP PA Other

Signature: _____ Date: _____

Address: _____

Phone: _____ Liscense/UPIN Number: _____

