Reins From Above Therapeutic Riding Center, Inc.

86 Polenta Road
Smithfield, NC 27577
Phone: 919-938-1556
Website: www.reinsfromabove.org

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
(To be completed annually by Primary Physician)

DATE:

Participant's Name:____ Date of Birth:___________________

Address:____

Height:____________________ Weight:________________

Name of Parent/Guardian/Adult Caregiver, if any:____

Diagnosis:____ Date of onset:________________________

**For persons with Down Syndrome: ? Negative Cervical X-ray for Atlantoaxial Instability X-ray Date:________________

? Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot ? Yes, Date: _______________ ? No

Seizure Type_________________________Controlled____________________________________Date of last seizure__________

Medications:____

Precautions for outdoor activities? (Allergies, sun/heat sensitivity, asthma, etc.)____

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			

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Other			

Mobility: Independent Ambulation ?Yes ? No; Crutches ? Yes ? No; Braces ? Yes ? No Wheelchair ? Yes ? No
Please indicate any special precautions____

PHYSICIAN'S STATEMENT

Participant's Name:____

PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. However, I understand that Reins From Above Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications. I concur that a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) may be helpful in the implementing of an effective equestrian program.

Physician Name (Please Print)____

Physician Signature:_______________________________ Date____________________

Address_________________________City______________________State_______Zip_________

Phone: ____

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Information for Physician

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

Orthopedic	**Medical/Surgical**
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	Allergies Cancer Poor Endurance Recent Surgery Diabetes Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension Serious Heart Condition Stroke (Cerebrovascular Accident)
Neurologic Hydrocephalus/shunt Spina Bifida Tethered Cord Chiari II Malformation Hydromyelia Paralysis due to Spinal Cord Injury Seizure Disorders	**Secondary Concerns** Behavior Problems Age under 2 years Age 2-4 years Acute exacerbation of chronic disorder Indwelling catheter

Please complete forms and send to:
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