HorsePlay Hippotherapy & Therapeutic Riding, Inc.
Rider's Medical History & Physician's Statement

Rider: _____ DOB: _____ Height: _____ Weight: _____
Primary diagnosis:_____
Secondary diagnosis:_____
Past/Prospective surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y/ N Date of last seizure: _____
Shunt present: Y/N Date of last revision: _____
Special precautions/needs:_____
Independent Ambulation: Y/N Assisted Ambulation: Y/N Wheelchair: Y/N
Braces/Assistive Devices:_____
For those with Down Syndrome: AtlantoDens Internal X-rays, date: _____ Result: + -
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past difficulties in the following systems/areas, including surgeries:

Challenge	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic 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 heal professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.
Name/Title: _____MD DO NP PA Other_____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____