

**PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

**{Please complete this form thoroughly}**

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

MOBILITY: Independent Ambulation Y N      Assisted Ambulation Y N      Wheelchair Y N

BRACES/ASSISTED DEVICES \_\_\_\_\_

PAST AND PROSPECTIVE SURGERIES \_\_\_\_\_

SEIZURES: TYPE \_\_\_\_\_ CONTROLLED \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

DATE OF LAST SEIZURE \_\_\_\_\_

SHUNT PRESENT \_\_\_\_\_ DATE OF LAST REVISIONS \_\_\_\_\_

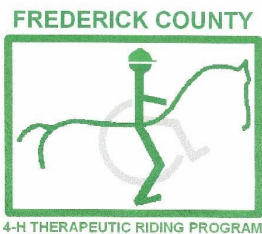
SPECIAL PRECAUTIONS/NEEDS \_\_\_\_\_

*Physicians: Please complete and/or update the participant's medical history. The following conditions may suggest precautions and/or contraindications to equine activities. Note whether these conditions are present and to what degree. Address occurrences over the past year including surgeries, illnesses, hospitalizations, medications, treatment, weight or behavior. If this person has Down syndrome or other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.*

**SYSTEMS/AREAS**

**COMMENTS**

AUDITORY/HEARING AIDS	
VISION/GLASSES	
CIRCULATORY	
ORTHOPEDIC LIMITATIONS	
• OSTEOPOROSIS	
• PATHOLOGICAL FRACTURE	
• JOINT SUBLUXATION	
• JOINT DISLOCATION	
• ARTHRITIS	
OPEN SORES/WOUNDS	
SPEECH/LANGUAGE	
INCONTINENCE	
ALLERGIES	
MUSCLES	
ATAXIA OR APRAXIA	



PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

*Physicians: Please complete and/or update the participant's medical history. The following conditions may suggest precautions and/or contraindications to equine activities. Note whether these conditions are present and to what degree. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight or behavior. If this person has Down syndrome or other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.*

SYSTEMS/AREAS	COMMENTS
CARDIAC CONDITION	
PULMONARY	
BLOOD PRESSURE CONTROL	
SPASTICITY/RIGIDITY	
LEARNING DISABILITY	
PAIN	
PSYCHOLOGICAL (IQ)	
GUILLIAN-BARRE/MS	
WEIGHT CONTROL DISORDER	
STRUCTURAL SCOLIOSIS	
BALANCE/COORDINATION	
NEUROLOGIC	
ALANTTOAXIAL INSTABILITY	
OTHER	
OTHER	

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the Frederick County 4H Therapeutic Riding Program will weigh the medical information given against the existing precautions and contraindications.

Name/Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_ License/UPIN Number \_\_\_\_\_