DATE _____

FREDERICK COUNTY

4-H THERAPEUTIC RIDING PROGRAM

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	

DATE _____

FREDERICK COUNTY 4-H THERAPEUTIC RIDING PROGRAM

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 PREASSURE CONTROL	
SPASTICITY/RIGIDITY	
LEARNING DISABILITY	
PAIN	
PSYCHOLOGICAL (IQ)	
GUILLIAN-BARRE/MS	
WEIGHT CONTROL DISORDER	
STRUCTURAL SCOLIOSIS	
BALANCE/COORDINATION	
NEUROLOGIC	
ALANTOAXIAL 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 _____