Greystone Manor Therapeutic Riding Center

Participant's Name_____ Date_____

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Please print clearly and complete BOTH sides

Physician Release for Equine Assisted Services at Greystone Manor Therapeutic Riding Center.

MEDICAL HISTORY

Date of Exam: _____ ***MUST BE SIGNED BY MD, DO, CRNP, FNP, or PA***

Patient's Name: _____ DOB (MM/DD/YYYY): _____ Age: _____

Sex: M F Race (Optional): _____ Height: _____ Weight / lbs: _____

Diagnosis: _____ Date of Onset: _____

Tetanus Shot: (*Circle one*) No Yes (Date ____/____/____)

Allergies: _____

Medications (Type, Purpose, Dose):

_____

_____

_____

Any new student entering the program as of 2021, must be under our 185 lb weight limit in order to ride at GMTRC. If the student is over this weight, they may be offered unmounted horsemanship lessons.

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to equine assisted services. Therefore, please circle any conditions that are present and indicate to what degree.

ORTHOPEDIC

Spinal Fusion
Spinal Instabilities/Abnormalities
Alanto-axial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Disease

NEUROLOGIC

Hydrocephalus/shunt
Spina bifida
Tethered Cord
Chiari 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

MEDICAL/SURGICAL

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

NOTE: Physician signature required on side 2 - please complete all areas applicable.

Greystone Manor Therapeutic Riding Center

Participant's Name_____ Date_____

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Please indicate if patient has a history of the following secondary problems by checking YES or NO.
If YES, please include COMPLETE pertinent information.

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual Impairment			Glasses?	Independent Ambulation			
Speech Impairment				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Cognitive Impairment				Canine Assist			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures*			Type	Controlled			Date of last Seizure

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of atlanto-axial instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No
☐ ☐ Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY _____
☐ ☐ If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old please state the result of the most recent visual examination conducted within the past 6 months:

□ The client has not had a timely physical examination and so cannot at this point be so certified.

□ The client's annual physical examination reveals no symptoms of AAI

□ The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

CERTIFICATION: I have reviewed the above health information and examined the named participant. I certify that there is no medical evidence available to me that would preclude the participant's taking part in equestrian activities. This certification is valid for up to three years.

Physician's Signature: _____ Print Physician's Name: _____

PARTICIPANTS WITH SEIZURE DISORDER - Please Print clearly

The standards we have adopted have been developed by PATH (Professional Association of Therapeutic Horsemanship International) who recommends the following information for equine assisted service centers for riders with seizure disorders.

Would you consider participant's seizures to be?

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:
Date of last seizure:
Typical motor activity during seizure:
Description of patient's behavior during seizure:

NOTE: PHYSICIAN'S SIGNATURE REQUIRED

I have reviewed the participant's health information and examined the named participant. I certify that there is no medical evidence available to me that would preclude the participant's taking part in (please check) _____ mounted equestrian assisted services; _____ unmounted equestrian assisted services.

Physician's Signature	**Date:**
Physician's Name *(Please print)*:	**Physician's Phone:**
Address:	**Physician's Fax:**