

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Please print clearly and complete BOTH sides

Page 1 of 2

Physician Release for Equine Assisted Activities & Therapies 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 activities. 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.

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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 activities and therapies 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:

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 activities; _____ unmounted equestrian activities.

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