

**PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT**

Participant: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Diagnosis & Date of Onset: \_\_\_\_\_

Mobility: (please circle all that apply) Independent Needs Assistance Braces/Asst. Devices Wheelchair

Special Precautions/Needs: \_\_\_\_\_

Seizures? If yes, type: \_\_\_\_\_ Controlled Y N Date of Last Seizure \_\_\_/\_\_\_/\_\_\_

*For Persons With Down Syndrome:*

Please circle and date

Negative Cervical X-Ray for Atlantoaxial Instability **YES NO** \_\_\_/\_\_\_/\_\_\_

Negative for Clinical Symptoms of Atlantoaxial Instability **YES NO** \_\_\_/\_\_\_/\_\_\_

Tetanus Shot? **YES NO** \_\_\_/\_\_\_/\_\_\_

CONDITIONS:

Auditory	YES	NO
Visual	YES	NO
Speech	YES	NO
Cardiac	YES	NO
Circulatory	YES	NO
Peripheral Vascular Disease	YES	NO
Varicose Veins	YES	NO
Hemophilia	YES	NO
Hypertension	YES	NO
Stroke	YES	NO
Pulmonary	YES	NO
Muscular	YES	NO
Diabetes	YES	NO
Poor Endurance	YES	NO
Cancer	YES	NO
Indwelling Catheter	YES	NO
Learning Disability	YES	NO
Psychological	YES	NO
Peripheral Neuropathy	YES	NO
Recent Surgery	YES	NO
Migraines	YES	NO
Arthritis	YES	NO
High Blood Pressure	YES	NO
Other (please explain below)	YES	NO

NEUROLOGICAL:

Hydrocephalus/Shunt	YES	NO
Date of last revision	___/___/___	
Spina Bifida	YES	NO
Tethered Cord	YES	NO
Chiari II Malformation	YES	NO
Hydromyelia	YES	NO
Paralysis from Spinal Cord		
Injury	YES	NO
Other (please explain below)	YES	NO

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ORTHOPEDIC:

Spinal Fusion	YES	NO
Spinal Abnormalities	YES	NO
Scoliosis	YES	NO
Kyphosis	YES	NO
Lordosis	YES	NO
Hip Subluxation	YES	NO
Hip Dislocation	YES	NO
Osteoporosis	YES	NO

(over)

**Medical History and Physician Statement, page 2**

ORTHOPEDIC (cont'd):

Pathologic Fractures	YES	NO
Coxas Arthrosis	YES	NO
Heterotopic Ossification	YES	NO
Osteogenesis Imperfecta	YES	NO
Cranial Defects	YES	NO
Spinal Orthosis	YES	NO
Internal Spinal	YES	NO
Stabilization Devices	YES	NO
Other (please explain below)	YES	NO

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To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that Therapeutic Riding of Tryon 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 health professional (e.g., PT, OT, SLP, psychologist, etc.) in the implementation of an effective equine activity program.

Physician's Name: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_