Therapeutic Riding Of Tryon
The Therapeutic Riding Program at FENCE

3381 Hunting Country Road,
Tryon NC 28782
828-859-9021
Fax: 828-859- 9315
Email: therapeuticriding@fence.org

PARTICIPANT MEDICAL HISTORY & PHYSICIAN STATEMENT

Participant: _____ DoB _____ 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 YES NO 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

_____

_____

_____

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
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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_____

Continued over ……

Participant Medical History & Physician Statement, continued

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

_____

_____

_____

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: _____