(PHYSICIAN)

Peg's Therapeutic Ponies, INC
1055 Wales Run
Mount Washington, KY 40047
(502) 955-4152

Date:______________

Your patient, _________________________ (participant's name) is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following condition may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

- Atlantoaxial Instability (include neurologic symptoms)
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint Subluxation/Dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion/Fixation
- Spinal Instability/Abnormalities

NEUROLOGIC

- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II Malformation/Tethered
- Cord/Hydromyelia

OTHER

- Age (under 4 years)
- Indwelling Catheters
- Medications (i.e. photosensitivity)
- Poor Endurance
- Skin Breakdown

MEDICAL/PSYCHOLOGICAL

- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self and others
- Exacerbations/Medical conditions
- Fire Settings
- Heart Conditions
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address or phone indicated above

Sincerely,
Peg Edwards, President

(PHYSICIAN)

Rider's Medical History and Physician's Statement

To be completed annually

Name: ____ Date of Birth___________________

Address: ____

Name of Parent/Guardian: ____

Diagnosis: ____ Date of Onset: _________________

**For Persons with Down Syndrome:

___ Negative Cervical X-Ray for Atlantoaxial instability X-Ray Date_______________

___ Negative for clinical symptoms of Atlantoaxial instability

Tetnus Shot: Yes __ No __ Date___________ Height__________ Weight ____________

Seizure Type: _____________________ Controlled _____________ Date of last seizure __________

Medications ____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas Yes No Comments

Auditory____

Visual____

Speech____

Cardiac____

Circulatory____

Pulmonary____

Neurological____

Muscular____

Orthopedic____

Allergies____

Learning Disability____

Mental Impairment____

Psychological Impairment____

Other____

Mobility: Independent Ambulation: Yes__ No__ Crutches: Yes__ No__

Braces: Yes__ No__ Wheelchair: Yes__ No__

Please indicate any special precautions:____

____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center 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, Speech, Psychologist, etc.) in the implementing of an effective equestrians program.

Physician Name (please print):____

Physician Signature: ____

Address____________________________ City: ________________ State: _____ Zip: ___________________

Phone: ( )______________________ Date:______________________

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

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

Neurologic

Hydrocephalus/Shunt
Spina Bifida
Tethered Cord
Seizure Disorders
Hydromyelia
Chiari II Malformation
Paralysis due to Spinal Cord Injury

Medical/Surgical

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

Secondary Concerns

Behavior Problems
Age (under 2 years)
Age (2-4 years)
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

(PHYSICIAN)

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Osteoporosis
Pathological Fractures
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Blood Pressure
Dangerous to self or others
Exacerbation of Medical Conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

OTHER

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Indwelling Catheters
Medications (i.e. photosensitivity)
Porr Endurance
Skin Breakdown

(PHYSICIAN)

Therapeutic and Safety Issues

Check and describe applicable issues (indicate current or history of):

__ Inattention
__ Hyperactivity
__ Lack of Concentration
__ Learning Disabilities
__ Developmentally Delayed
__ Mentally Challenged
__ Boundary Issues
__ Social Skills Problems
__ Problems with Peers
__ Separation Anxiety
__ Anxiety
__ Phobias
__ Aggressive
__ Assaultive
__ Manipulative
__ Unpredictable or Dangerous Behavior
__ Psychosomatic Symptoms
__ Medical Issues
__ Self-Injurious Behavior
__ Suicidal Ideation
__ History of Runaway
__ Issues of Parental Support
__ Issues of Family Support
__ Sexual Abuse/Acting Out
__ History of Physical Abuse
__ Emotional Abuse
__ Hallucinations
__ Delusions
__ Illusions
__ Dissociation
__ Substance Abuse Problems
__ Legal Problems
__ School Problems
__ History of Animal Abuse
__ Arson
__ Seizure Disorder
__ Possible Medication Side Effects

____________________________________ _________________________

Information Source Date Completed

Ideally this form is designed to be used in conjunction with the NARHA RIDER'S Medical History, Physician's Statement and Physician's Release Statement.