



# Rider's Medical History and Physician's Statement

Name: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Name of Parent/Guardian: \_\_\_\_\_

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

Tetanus 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.

**\*\* Only For Persons with Down Syndrome**

Cervical X-ray for Atlantoaxial Instability: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_ X-Ray Date: \_\_\_\_\_

Area	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 Special Spirit Inc Therapeutic Riding Center will weigh the medical information above against the existing precautions and contradictions. 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 equestrian program.

Physician Name (please print) \_\_\_\_\_

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_