Date: _____

Dear Health Care Provider:

This patient is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. The following conditions, if present, may represent precautions or contraindications to equine activities. Therefore, when completing this form, please circle below whether these conditions apply to this patient.

Orthopedic
Atlantoaxial Instabilities
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
Joint Subluxation and Dislocation
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/Abnormalities

Medical/Surgical/Psychological
Allergies
Animal Abuse
Blood Pressure Control
Cancer
Cardiac Condition
Dangerous to Self and Others
Diabetes
Fire Settings
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Poor Endurance
Respiratory Compromise
Recent Surgeries
Substance Abuse
Stroke
Thought Control Disorders
Weight Control Disorders

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

Other Concerns
Age – Under 4 Years
Behavior Problems
Implanted Pumps
Indwelling Catheters
Medical Equipment
Medications – i.e. Photosensitivity
Skin Breakdown

Mobility: _____***Independent Ambulation*** _____***Assisted Ambulation*** _____***Wheelchair***

Braces/Assistive Devices: _____

For Participants with Seizures:

Seizure Type: _____ ***Controlled? Yes No Date of Last Seizure:*** _____

Seizure Complexity: _____***Mild (Barely noticeable)*** _____***Moderate*** _____***Severe (Complete Loss of Control)***

Typical activity during a seizure: _____

Average duration of the seizures: _____***Post-Seizure Behavior:*** _____

For Participants with Down Syndrome: ***The annual medical clearance form must include a neurologic exam that specifically denies any symptoms consistent with Atlantoaxial Instability (AAI).***

Date of last Physical Exam: _____ ***This child continues to be symptom free of AAI: Yes _____ No _____***

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact us at the address/phone/email indicated on this form.

Sincerely,

Karen M. Sanchez

Karen M. Sanchez
Executive Director

Physician's Statement & Medical Clearance

Participant:_____ DOB:_____ Height:Weight:_____

Address:_____

Diagnosis:_____ Date of Onset:_____

Medications:_____

Shunt Present: Y N Date of last revision:_____

Special Precautions/Needs:_____

_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Systems/Areas	Yes	No	Comments
Auditory	☐	☐	
Visual	☐	☐	
Tactile Sensation	☐	☐	
Speech	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Integumentary/Skin	☐	☐	
Immunity	☐	☐	
Pulmonary	☐	☐	
Neurological	☐	☐	
Muscular	☐	☐	
Balance	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning Disability	☐	☐	
Cognitive	☐	☐	
Emotional/ Psychological	☐	☐	
Pain	☐	☐	
Other	☐	☐	

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities/therapies. I understand that The Shane Center for Therapeutic Horsemanship will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The Shane Center for Therapeutic Horsemanship for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____

Signature_____ Date:_____

Address_____ City_____ State_____ Zip_____

Phone_(_____)_____