Reins From Above Therapeutic Riding Center, Inc.

86 Polenta Road
Smithfield, NC 27577
Phone: 919-631-9294
Website: www.reinsfromabove.org

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
(To be completed annually by Primary Physician)

DATE:

Participant's Name:_____ Date of Birth:_____

Address:_____

Height:_____ Weight:_____

Name of Parent/Guardian/Adult Caregiver, if any:_____

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.

Tetanus Shot ? Yes, Date: _____ ? No

Seizure Type_____Controlled_____Date of last seizure_____

Medications:_____

Precautions for outdoor activities? (Allergies, sun/heat sensitivity, asthma, etc.)_____

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 Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation ?Yes ? No; Crutches ? Yes ? No; Braces ? Yes ? No Wheelchair ? Yes ? No
Please indicate any special precautions_____

PHYSICIAN'S STATEMENT

Participant's Name:_____

PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. However, I understand that Reins From Above Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications. I concur that a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) may be helpful in the implementing of an effective equestrian program.

Physician Name (Please Print)_____

Physician Signature:_____ Date_____

Address_____City_____State_____Zip_____

Phone: _____

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	**Medical/Surgical**	
Spinal Fusion	Allergies	
Spinal Instabilities/Abnormalities	Cancer	
Atlantoaxial Instabilities	Poor Endurance	
Scoliosis	Recent Surgery	
Kyphosis	Diabetes	
Lordosis	Peripheral Vascular Disease	
Hip Subluxation and Dislocation	Varicose Veins	
Osteoporosis	Hemophilia	
Pathologic Fractures	Hypertension	
Coxas Arthrosis	Serious Heart Condition	
Heterotopic Ossification	Stroke (Cerebrovascular Accident)	
Osteogenesis Imperfecta		
Cranial Deficits		
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Neurologic	**Secondary Concerns**
Hydrocephalus/shunt	Behavior Problems
Spina Bifida	Age under 2 years
Tethered Cord	Age 2-4 years
Chiari II Malformation	Acute exacerbation of chronic disorder
Hydromyelia	Indwelling catheter
Paralysis due to Spinal Cord Injury	
Seizure Disorders	

Please complete forms and send to:
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