Physician Medical History & Physician's Statement

Participant_____DOB_____Height_____Weight_____
Address _____
Diagnosis:_____Date of Onset_____
Past/Prospective Surgeries_____
Medications_____
Seizure Type:_____ Controlled Y N Date of Last Seizure_____
Shunt Present: Y N Date of last revision:_____
Special Precautions/Needs:_____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices:_____
for those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ___ Present___Absent
Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activates.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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

Name/Title_____ MD DO NP PA other_____
Signature_____Date_____
Address_____
Phone(_____)_____ License/UPIN Number_____