Dear Health Care Provider:

Your patient:_____is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, circle any contraindications that are present, and note to what degree. If no contraindications exist, please indicate this.

Orthopedic

Amputation

Arthrogryposis

Atlantoaxial Instability – include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint sublixation/dislocation

Osteogenesis Imperfecta

Osteoporosis

Pathologic Fractures

Spinal Cord Injury Above T-6

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age – under 4 years

Hypertonia

Indwelling Catheters/Medical Equipment

Medications – e.g., photosensitivity

Persistent Primitive Reflexes

Medical/Psychological

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Exacerbations of Medical Conditions (e.g., RA)

Fire Setting

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Poor Endurance

Poor Trunk Control

Skin Breakdown

To my knowledge there are no existing contraindications

Name/Title:_____MD DO NP PA Other:_____

Signature:_____ Date:_____

4537 Walpole Rd. High Point, NC 27265 – phone (336)931-1424 – fax (336)905-6936 - ride@horsepower.org
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HORSEPOWER
THERAPEUTIC LEARNING CENTER

Participant's 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 patients with Down Syndrome : Neurologic Symptoms of Atlanto Axial Instability: ☐ Present ☐ Absent

Neurologic Symptoms of Focal Neurologic Disorder : ☐ Present ☐ Absent

Date of Last Neurologic Exam:_____ Date of Last Radiograph:_____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
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 and/or therapies. I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other:_____

Signature:_____ Date:_____

Address:_____

Phone_____ License/UPIN Number:_____

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