Whispering Meadows Ranch PHYSICIANS FORM

Dear Health Care Provider:

Your patient is interested in participating in supervised equine-assisted activities.

_____
(participant's name)

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

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Patients Name: _____ Date of Birth: _____

Height:_____ Weight;_____

Address: _____

Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

Diagnosis: Please check one of the following. If more than one diagnosis applies, please number in order of importance.

Spinal Fusion ____ Spinal Instabilities/Abnormalities____ Atlantoaxial Instabilities ____

Scoliosis ____ Kyphosis____ Lordosis____ Osteoporosis____

Hip Subluxation/Dislocation____ Fractures____ Coxas Arthrosis____

Heterotopic Ossification____ Cranial Deficits____ Spinal Orthoses_____

Internal Spinal Stabilization Rods____ Hydrocephalus/Shunt____

Spina Bifida____ Tethered Cord____ Chiari II Malformation____ Hydromyelia ____

Paralysis due to spinal cord injury____ Seizure Disorders____ Cancer____

Poor Endurance____ Recent Surgery____ Diabetes____ Hemophilia____

Hypertension____ Serious Heart condition____ Stroke____

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** For Persons with Down Syndrome:

▫ Negative Cervical X-ray for Atlantoaxial Instability

▫ Negative for clinical symptoms of Atlantoaxial Instability

X-ray Date: _____

Tetanus Shot: ▫ Yes ▫ No

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. If yes, please comment.

Auditory _____ Visual _____

Speech _____ Cardiac_____

Circulatory _____ Pulmonary_____

Neurological _____ Muscular _____

Orthopedic _____ Allergies _____

Learning Disability: _____

_____

_____

Mental or Psychological Impairment:_____

_____

_____

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Please indicate any special precautions:

_____

_____

_____

_____

_____

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 the center at the address/phone number indicated above.

Physician's Name:

_____

Physician's Signature:

_____

Address: _____

Date: _____ Telephone: _____