



Participant's Physicians Statement and Medical History Form

Participants name: _____ DOB: _____

Height: _____ Weight: _____ Male Female

Address: _____

Diagnosis: _____

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: AtlantoDens Interval X-rays, date: _____ Result + -

Neurologic Symptoms of AtlantoAxial Instability: _____



30 Martin Drive Reinholds, PA 17569

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

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

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Triangle Therapeutic Riding will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations in the implementation of an effective equestrian program.

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

Signature: _____ Date _____

Address: _____

Phone: () _____ License/UPIN Number: _____