# PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

(To be completed by the participant's Health Care Provider.)

Dear Health Care Provider:

Your patient, _____ DOB: _____
*(participant's name)*
is interested in participating in supervised equine activities at Saddle Up!.

In order to safely provide this service, Saddle Up! 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.

**ORTHOPEDIC**
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

**NEUROLOGIC**
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**OTHER**
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

**MEDICAL/PSYCHOLOGICAL**
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 indicated above. Please fax or mail the form back to Saddle Up! once it's completed.

Sincerely,

Saddle Up! Program Director
(615) 794-1150 x24
(615) 794-7973 Fax

# PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

(To be completed by the participant's Health Care Provider.)

Participant Name: _____ Date of Birth: _____

Date of Last Physical: _____ Recent Height: _____ Recent Weight:_____

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis *(if applicable)*: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Seizure Type: _____ Controlled: ☐Y ☐N Date of Last Seizure: _____

Shunt Present: ☐Y ☐N Date of last revision: _____

Special Precautions/Needs:_____

_____

Mobility *(circle one)*: ☐Independent Ambulation ☐Assisted Ambulation ☐Wheelchair Other: _____

Braces/Assistive Devices: _____

**PLEASE GIVE DETAILS REGARDING DIAGNOSIS IN CHART BELOW.**

*Indicate current or past special needs in the following systems/areas, including surgeries:*

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

**PLEASE COMPLETE ALL INFORMATION BELOW.**

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Saddle Up! will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Saddle Up! for ongoing evaluation to determine eligibility for participation.

Name/Title (please print): _____☐MD ☐DO ☐NP ☐PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ License/UPIN Number: _____

# Antlantoaxial Instability (AAI) Annual Documentation Form

**(To be completed by the Health Care Provider of Saddle Up! participants diagnosed with Down Syndrome)**

Participant Name: _____ Date of Birth: _____

Dear Parent, Guardian, and/or Health Care Provider,

The Professional Association of Therapeutic Horsemanship requires that all participants with Down Syndrome have:
A: A yearly medical examination including a complete neurologic exam that shows no evidence of atlantoaxial instability.
B: Certification by a physician that an examination DID NOT reveal atlantoaxial instability or focal neurologic disorder.

In order for Saddle Up! to ensure the safety of our participants with Down Syndrome, we need this form completed annually. If you have any questions or concerns about getting this form completed please feel free to contact the Saddle Up! office at (615) 794-1150.

Sincerely,

Saddle Up! Records
(615) 794-1150
(615) 794-7973 (fax)

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**This segment of the form is to be completed by the participant's Health Care Provider.**

**Are neurologic symptoms of atlantoaxial instability (please check one), ____ Present OR ____ Absent in the participant listed above?**

**Please complete ALL information below.**

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Saddle Up! will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Saddle Up! for ongoing evaluation to determine eligibility for participation.

Name/Title (please print): _____ ☐MD ☐DO ☐NP ☐PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ License/UPIN Number: _____