

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: _____

Atlantoaxial 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)

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: _____