Rider's Annual Medical History and Physician's Statement

Name:_____ Date of Birth:_____
Address:_____ City:_____ Zip:_____
Name of Parent or Guardian:_____
Diagnosis:_____ Date of Onset:_____
For Persons with Down's Syndrome:
[ ] Negative cervical x-ray for Alkintouxial Instability X-Ray Date:_____
[ ] Negative for clinical symptoms for Allantocixtal Instability
Tetanus Shot: [ ]Yes [ ]No Date:_____ Height:_____in Weight:_____lbs
Seizure Type:_____ Controlled:_____ Date of last seizure:_____
Medication(s):_____

_____

Please indicate if the patient has a problem and/or surgeries in any of the following areas by checking Yes or No. If yes, please comment.

Auditory	[ ] Yes [ ] No	Comments:_____
Visual	[ ] Yes [ ] No	Comments:_____
Speech	[ ] Yes [ ] No	Comments:_____
Cardiac	[ ] Yes [ ] No	Comments:_____
Circulatory	[ ] Yes [ ] No	Comments:_____
Pulmonary	[ ] Yes [ ] No	Comments:_____
Neurological	[ ] Yes [ ] No	Comments:_____
Muscular	[ ] Yes [ ] No	Comments:_____
Orthopedic	[ ] Yes [ ] No	Comments:_____
Allergies	[ ] Yes [ ] No	Comments:_____
Learning Disabilities	[ ] Yes [ ] No	Comments:_____
Mental Impairment	[ ] Yes [ ] No	Comments:_____
Psychological Impairment	[ ] Yes [ ] No	Comments:_____
Other	[ ] Yes [ ] No	Comments:_____

Mobility: Independent Ambulation [ ] Yes [ ] No Crutches [ ] Yes [ ] No
Wheel Chair [ ] Yes [ ] No Braces [ ] Yes [ ] No

Please indicate any special precautions:_____

_____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical informal ion above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e. g PT, OT, Speech, Psychologist, etc) in the implementation of an effective equestrian program.

Physician Name (please print):_____

Physician's Signature:_____

Address:_____ Phone:_____ Date:_____