Miracles in Motion
THERAPEUTIC EQUESTRIAN CENTER

RIDER'S MEDICAL HISTORY & PHYSICIAN STATEMENT

Date: _____

Dear Health Care Provider:

Your patient _____ is interested in participating in supervised equine activities.
(Participant's Name)

In order to safely provide this service, our center requests that you complete the our 2-page 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 by circling the condition and describing below. Please complete the Participant Medical History & Physician Statement, as well.

Orthopedic
Antoaxial instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability Abnormalities

Neurological
Hydrocephalus/Shunt
Seizure
Spina Bifada/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age - Under 4 years
Indwelling Catheters/Medical Equipment Medications (e.g. Photosensitivity)
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Dangerous to Self or Others
Exacerbations of Medical Conditons (e.g. RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Recent Surgeries
Respiratory Compromise
Substance Abuse
Thought Control Disorders
Weight Control Disorder
Blood Pressure Control

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact Miracles in Motion via email or phone, as indicated below.

Miracles in Motion
THERAPEUTIC EQUESTRIAN CENTER

RIDER'S MEDICAL HISTORY & PHYSICIAN STATEMENT

Rider:_____ DOB:_____ Height: _____ Weight: _____
Address: _____
Diagnosis:_____ Date of Onset: _____
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 Neurologic Symptoms of Atlantoaxial Instability: □ Present □ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

FUNCTION/ CONDITION	Y	N	COMMENTS	FUNCTION/ CONDITION	Y	N	COMMENTS
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary/Skin				Emotional/Psychological			
Immunity				Pain			
Pulmonary				Other			
Neurologic							

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Miracles in Motion Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Miracles in Motion for ongoing evaluation to determine eligibility for participation.

Name/Title:		MD DO NP PA		Other:	
Signature:				Date:	
Address:					
Phone:		License/UPIN Number:			

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International