Rider's Medical History and Physician's Statement

Name: ____

Address______________________________City:_________________Zip:_______

Phone Number:__________________ E-Mail Address:________________________

Date of Birth: ____________ Name of Parent/Guardian:________________________

Diagnosis: __________________________________ Date of Onset: ____________

Tetanus Shot: Yes: ___ No: ____ Date: _________ Height: _________ Weight: ___________

Seizure Type: _______________________ Controlled: ______ Date of Last Seizure: ________

Medications: ____

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

***** Only For Persons with Down Syndrome***

Cervical X-ray for Atlantoaxial Instability: Positive: ______ Negative: _____ X-Ray Date: _____

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation:Yes __ No __ Crutches:Yes__ No __ Braces:Yes __ No _

Wheelchair: 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 Special Spirit Inc Therapeutic Riding Center will weigh the medical information above against the existing precautions and contradictions. 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 implementing of an effective equestrian program.

Physician Name (please print) ____

Physician Signature ____Date __________________

Address ____________________________________ City _________________ State ___ Zip _______

Phone _________________________________