

## INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

### Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Devices

### Neurologic

- Hydrocephalus/shunt
- Spina Bifida
- Tethered Cord
- Chiari II Malformation
- Hydromyelia
- Paralysis Due to Spinal Cord Injury
- Seizure Disorders

### Medical/Surgical

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular Accident)

### Secondary Concerns

- Behavior Problems
- Age under Two Years
- Age Two to Four Years
- Acute Exacerbation of Chronic Disorder
- Indwelling Catheter

**TEAM**  
**Rider's Medical History and Physician's Statement**  
*(To be completed annually by physician)*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of On-set \_\_\_\_\_

\*\*The following questions apply to persons with Down's Syndrome.

Negative Cervical X-ray for Atlantoaxial Instability  Yes  No X-ray Date \_\_\_\_\_

Negative for clinical symptoms of Altantoaxial Instability  Yes  No

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.

Areas	Check One	Comments
Auditory	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Visual	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Circulatory	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulmonary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Orthopedic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychological Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**TEAM**

**Rider's Medical History and Physician's Statement** *(cont'd)*

Mobility *(check one)*      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 the therapeutic riding center will weight the medical information above and against the existing precautions and the contraindications. I concur with a review of this person's abilities/limitations by a licensed/credential health professional (e.g. PT, OT, Speech Therapist, Psychologist, etc.) in implementing of an effective equestrian program.

Physician Name *(please print)* \_\_\_\_\_

Physician Signature \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_