Participant's Medical History & Physician's Statement

Participant: ________________________________ DOB _______ Height _______ Weight ______
Address: ____
Diagnosis: ____
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 **Y N** Assisted **Y N** Wheelchair **Y N**
Braces/Assistive Devices: ____
For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability **Y N**

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

			(write comments here)
Auditory	**Y**	**N**	
Visual	**Y**	**N**	
Tactile Sensation	**Y**	**N**	
Speech	**Y**	**N**	
Cardiac	**Y**	**N**	
Circulatory	**Y**	**N**	
Integumentary/Skin	**Y**	**N**	
Immunity	**Y**	**N**	
Pulmonary	**Y**	**N**	
Neurologic	**Y**	**N**	
Muscular	**Y**	**N**	
Balance	**Y**	**N**	
Orthopedic	**Y**	**N**	
Allergies	**Y**	**N**	
Learning Disability	**Y**	**N**	
Cognitive	**Y**	**N**	
Emotional/Psychological	**Y**	**N**	
Pain	**Y**	**N**	
Other	**Y**	**N**	

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

Name/Title:_________________________________ MD DO NP PA Other _______________
Signature: ____ Date _________________
Address: ____
Phone: (_____)___________________________ License/UPIN Number: ___________________