Calvin Center
Therapeutic Riding Program

Rider's Medical History and Physician's Statement

To be completed by applicant's physician. Please type or print. Use black or blue ink.

Applicant's Name _____ Date of Birth _____ Gender _____

Parent / Guardian _____

Address _____

City, State Zip _____

Diagnosis _____

Age of onset _____ Height _____ Weight _____

Please list current and past special needs in the following areas by checking YES or NO. If YES, please include complete information, including surgical history, pertaining to the situation. Attach an additional page if needed.

SPECIAL NEED	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
Auditory Impairment	○	○	
Attention Deficit / Hyperactivity	○	○	
Learning Disability	○	○	
Mental Impairment	○	○	
Psychological Impairment	○	○	
Speech Impairment	○	○	
Visual Impairment	○	○	Glasses / Contacts:
Allergies	○	○	Type of Reaction:

Calvin Center
Therapeutic Riding Program

Cardiac	○	○	
Circulatory	○	○	
Gastrointestinal - Gastrostomy	○	○	
Pulmonary - Asthma / COPD	○	○	
Neurological			
Hydrocephalus / Shunt	○	○	
Balance Impairment	○	○	
Sensory Loss	○	○	
Hypertonicity	○	○	
Hypotonicity	○	○	
Urological			
Incontinence	○	○	
Indwelling Catheter	○	○	
Muscular - Contractures	○	○	
Skeletal			
Spinal Column Injury	○	○	
Subluxing or Dislocating Joints	○	○	

Calvin Center
Therapeutic Riding Program

Laminectomy	○	○	
Spinal Fusion	○	○	
Scoliosis [include Degree / Type / Brace / Last X-Ray]	○	○	
Spondylolisthesis	○	○	
Osteoporosis	○	○	
Heterotrophic Ossification	○	○	
Fractures (Location? Healed?)	○	○	
Other	○	○	

For Persons with Down Syndrome:

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

Current clinical exam on date revealed ☐ *no symptoms* of Atlantoaxial Instability.

Comments:

Medications (type, purpose, dose):

Seizure Type: Controlled: Date of Last Seizure

Calvin Center
Therapeutic Riding Program

Comments:

Mobility Status:

Ambulatory: ☐ yes ☐ no

Assistive Device: ☐ cane ☐ crutches ☐ walker ☐ wheelchair ☐ other

Prosthetic/Orthotics: ☐ yes ☐ no If yes, please specify:

Please indicate special precautions or other notes:

Calvin Center
Therapeutic Riding Program

IN MY OPINION, THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE SIGNED.

Physician's Signature:

Physician's Name (Please Print):

Date: UPIN or License #:

Physician's Street Address:

City, State Zip:

Physician's Telephone Number:

***** Only signatures of MD's or DO's are accepted *****

INFORMATION FOR PHYSICIANS

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.

Orthopedic	**Medical/Psychological**
Atlantoaxial or other cervical instability – including neurologic symptoms	Allergies
Activity limiting arthritis	Animal Abuse
Cranial Deficits	Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans (activity limiting)	Blood Pressure Control
Joint subluxation/dislocation	Dangerous to self or others
Osteoporosis	Exacerbations of medical conditions
Pathologic Fractures	Fire Settings
Spinal Fusion/Fixation	Hemophilia
Spinal Instability/Abnormalities	Medical Instability
	Migraines
	PVD Respiratory Compromise
	Recent Surgeries
Other	Substance Abuse
Age – under 4 years	Thought Control Disorders
Indwelling Catheters	Weight Control Disorder
Medications – photosensitivity, balance, memory, dizziness, judgement	Neurologic
Poor endurance	Hydrocephalus/Shunt
Skin Breakdown	Seizure
	Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia