Date:________________

To: Health Care Provider completing the medical history and medical release

Your patient ________________________________ is interested in participating in a therapeutic equestrian program at EQUI-ED in Santa Rosa. In order to safely provide this service, students are required to obtain medical clearance before they may begin the riding program. Please note 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
Atlantoaxial 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

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered
Coed/Hydromyelia

Medical/Psychological
Allergies
Animal Abuse
Cardiac Conditions
Physical/Sexual/Emotional Abuse
Dangerous to Self or Others (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability-includeMigraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Other
Age-under 4 years
Indwelling Catheters/Medical Equipment
Medications-e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Therapeutic riding is a unique treatment modality providing a form of physical exercise and activity in which students are encouraged to test their abilities, develop their sense of balance and to improve their posture, coordination and self-image through the use of specially selected horses. Students having a variety of physical, cognitive, and emotional special needs can benefit. Therapeutic riding has been utilized in Europe, particularly Germany and England for many years. In the US, the Professional Association for Therapeutic Horsemanship (PATH) was formed in 1969. Currently there are over 800 PATH member centers engaging in therapeutic equestrian activities for the disabled in the United States.

Thank you for your assistance. If you have any questions or concerns, do not hesitate to contact us regarding this patient's participation.

Sincerely,

Maxine Freitas,
Equi-Ed Program Director
www.equi-ed.org
(707) 546-7737

Equi-Ed Equines and Education

Mailing address: 1535 Farmer's Lane #217 Santa Rosa, CA 95405
Message (707) 5-HORSES/546-7737 Fax: (707)942-0915 Website: www.equi-ed.org

Participant's Medical History and Physician's Statement

Participant: ______________________________________DOB____________ Height ________ Weight________

Diagnosis: ______________________________ __________Date of Onset: _________________________________
Past/Prospective Surgeries____
Medications (type, purpose, dose) ____ _____________

____
Seizure Type:____ Controlled: Y N Date of Last Seizure _________
Shunt present: Y N Assisted Ambulation: Y N Wheelchair: Y N Tetanus Shot: *Y N Date* _________
Braces/Assistive Devices: ____
COVID Vaccination and boosters *(required for participation) Dates:* __________. __________ ___________, __________
For those with Down syndrome: **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.

	No	Yes	If Yes, or History of, Describe
Auditory			
Learning Disability			
Emotional/Psychological			
Speech			
Visual			
Allergies			
Cardiac			
Circulatory			
Hemophilia			
Pulmonary			
Tactile Sensation			
Neurologic			
Balance			
Orthopedic			
Cognitive			
Pain			
Muscular			Contractures?
Skeletal			
Spinal Column Injury			
Laminectomy/Fusion			
Scoliosis-Degree/Type/Brace			Date of Last X-Ray
Kyphosis/Lordosis			Degree/Type
Spondyiolisthesis			
Spinal Abnormality			
Immunity			
Integumentary/Skin			
Other			

Please describe any medical problems not indicated above:____
____ _____________
Please describe any additional information that might help us work with this student.___________________________
____ ____

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 Equi-Ed will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Equi-Ed for ongoing evaluation to determine eligibility for participation.

Name/Title (please print) ______________________________ MD DO NP PA Other _______________Date ___________
Physician Signature ____ License/UPIN Number___________________
Address: ____ City: __________________________ State: _____ Zip ________
Phone (_____) _________________________ Email: ____