



## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

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 Ambulation  Y  N Assisted Ambulation  Y  N Wheelchair  Y  N

Braces/Assistive Devices: \_\_\_\_\_

*For those with Down Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result:  +  --

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

***Please indicate current or past special needs in the following systems/areas, including surgeries:***

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in equine assisted activities. However, I understand that Horseplay will weigh the medical information above against the existing precautions and contraindications.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Phone: (     ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_