Participant’s Medical History & Physician’s Statement

To be completed by participant’s physician

This form must be updated annually and submitted with required signatures

Physician, please note: The conditions noted on the accompanying medical history may represent a precaution or contraindication if present. When reviewing the medical history, please note whether these conditions are present and to what degree. Please be as specific as possible so that we will be able to best serve the rider’s needs. Texas Tech Therapeutic Riding and Therapy Center will make the final determination about an individual’s ability to participate in the program.

Participant Diagnosis (es):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific limitations not noted on the medical history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL Participants with Down Syndrome-Please Note:**

Due to the nature of Equine Assisted Activities and Therapies, we require that ALL individuals diagnosed with Down Syndrome must have an ANNUAL certification from their physician that a neurologic and/or physical examination reveals no sign of AAI or decrease in neurologic function:

a) Most recent cervical x-ray for AAI: [ ] Positive [ ] Negative Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b) Annual neurologic/physical exam for AAI/decreased neurologic function:

[ ] Positive [ ] Negative Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Riders with Brain related injury or surgery**

Any rider who has had any type of brain related injury or surgery will require the release from the treating neurologist.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as the treating physician, responsible for the health care of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that there are no restrictions or limitations

regarding the patient listed above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.D./P.A. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the attached medical history and release (participant’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in Equine Assisted Activities and Therapies at Texas Tech Therapeutic Riding and Therapy Center. I am aware and permit my patient to actively participate in the areas of EAAT including sitting astride a horse, grooming a horse and other equine related ground activities.

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

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD, DO, NP, PA, Other\_\_\_\_\_\_\_

License/UPIN # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Concern** | **Yes** | **No** | **History/Describe** |
| Auditory |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Allergies |  |  |  |
| Learning Disabilities |  |  |  |
| Mental Impairment |  |  |  |
| Neurological |  |  |  |
| Pain |  |  |  |
| Seizures Type: |  |  | Controlled Yes/No Last Seizure: \_\_\_/\_\_\_\_/\_\_\_\_\_ |
| Ossification |  |  |  |
| Osteoporosis |  |  |  |
| Psychological impairment |  |  |  |
| Asthma/COPD |  |  |  |
| Skeletal |  |  |  |
| Dislocating Joints |  |  |  |
| Laminectomy/Fusion |  |  |  |
| Scoliosis (Degree and Type) |  |  |  |
| Brace/Last X-ray |  |  |  |
| Spinal Column Injury |  |  |  |
| Subluxing Joints |  |  |  |
| Surgical Implants |  |  |  |
| Speech Impairments |  |  |  |
| Spondylolisthesis |  |  |  |
| Visual Impairments |  |  |  |
| Other: |  |  |  |
| Mobility |  |  |  |
| Independent Ambulation |  |  |  |
| Cane/Crutches/Walker |  |  |  |
| Prosthetics |  |  |  |
| Orthodics |  |  |  |
| Wheelchair |  |  |  |