



LOVE for Therapeutic Riding

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Tax ID 26-2965095
a faith-based, non-profit program 501 (c)(3)



RIDER Medical History & Physicians' Statement (PAGE 1 OF 2)

Participant Name:	Date of Birth:	Sex:	Race:	Height	Weight:
Name / Address of Guardian:			Tetanus Shot:	YES	NO
Diagnosis:			Date:	Date of Onset:	
Medications:					

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

** Please complete required information on page 2 for SEIZURE patients ** See Page 2 for list of precautions and contraindications

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No

Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY _____

If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old Please state the result of the most recent visual examination conducted within the past six months:

The client has not had a timely physical examination and so cannot at this point be so certified.

The client's annual physical examination reveals no symptoms of AAI

The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's signature _____ Date of Exam: _____

Physician's Name (print) _____ Physician's Phone: _____

Address: _____ Physician's Fax: _____

**RIDER Medical History & Physicians' Statement
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SEIZURE DISORDER PARTICIPANTS

NARHA, recommends the following information for NARHA Operating Centers for riders with seizure disorders.
 Would you consider _____'s seizures to be:

- Completely controlled Very well controlled Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at LOVE for TR:	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and, if so, to what degree.

ORTHOPEDIC

Spinal Fusion
 Spinal Instabilities/Abnormalities
 Alantoaxial Instabilities
 Scoliosis
 Kyphosis
 Lordosis
 Hip Subluxation and Dislocation
 Osteoporosis
 Pathologic Fractures
 Coxas Arthrosis
 Heterotopic Ossification
 Osteogenesis Imperfecta
 Cranial Deficits
 Spinal Orthoses
 Internal Spinal Stabilization
 Disease

NEUROLOGIC

Hydrocephalus/shunt
 Spina bifida
 Tethered Cord
 Chiari I Malformation
 Hydromyelia
 Paralysis due to Spinal Cord
 Injury
 Seizure Disorders

SECONDARY CONCERNS

Behavior Problems
 Age under 4 years
 Age 4-5 years
 Acute exacerbation of chronic
 disorder
 Indwelling catheter

MEDICAL/SURGICAL

Allergies
 Cancer
 Poor Endurance
 Recent Surgery
 Diabetes
 Peripheral Vascular Disease
 Varicose Veins
 Hemophilia
 Hypertension
 Serious Heart Condition
 Stroke (Cerebrovascular)
 Accident