Participant's Medical History & Physician's Statement
To Be Completed by Medical Personnel ONLY

Participant:_______________________________ DOB:____________ Height: ________Weight: __________
Parent/Guardian NAME: ______________________________________ Phone Number:___________________
Diagnosis(es): ____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 Needs/Precautions__________________
Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:____

For those riders with Down Syndrome only:
Neurologic Symptoms of Atlanto-Axial Instability: ❑ Present ❑ Absent

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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Project R.I.D.E., Inc will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Project R.I.D.E., Inc. for ongoing evaluation to determine eligibility for participation.

Completed by (circle): MD DO NP PA Other

Doctor's Signature: _________________________Date: __________________

License # _________________________________

Please imprint office stamp below:

Please return completed form to:

Project R.I.D.E., Inc.
Fax: (916) 686-0500
8840 Southside Ave. Elk Grove, CA 95624
ride@projectride.org (916) 685-7433

Information for Physician

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

Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Neurological Symptoms of Atlantoaxial Instabiliities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxes Arthrosis
- Heterotrophic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Devices

Neurologic

- Hydrocephalus/Shunt
- Spina Bifida
- Tethered Cord
- Chiari 2 Malformation
- Hydromyelia
- Paralysis due to Spinal Cord Injury
- Seizure Disorders

Medical/Surgical

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

Secondary Concerns

- Behavior Problems
- Age under two years
- Age two - Four years
- Acute exacerbation of Chronic Disorder
- Indwelling Catheter