

To: _____

Date: _____

To: Physician completing the medical history and medical release

Re: Patient Name: _____

The above named individual is interested in participating in a therapeutic riding program at EQUI-ED in Santa Rosa. Students are required to obtain medical clearance before they may begin the riding program.

We have provided you with some information regarding the potential beneficial effects of therapeutic riding along with recommended precautions and contraindications regarding student participation.

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 North American Riding for the Handicapped Association (NARHA) was formed in 1969. Currently there are over 600 NARHA member centers engaging in therapeutic riding activities for the disabled in the United States.

Students receive individualized instruction and are assisted by one to three volunteers to provide a feeling of confidence and sociability, as well as for physical safety. The course is taught by certified riding instructors who have received training specific to teaching riding to individuals with disabilities.

Please feel free to contact us if you have any questions or concerns.

Sincerely,

Maxine Freitas

Maxine Freitas
Program Director/Instructor
(707) 546-7737

Equi-Ed

Equines and Education

Mailing address: 1535 Farmer's Lane #217 Santa Rosa, CA 95405

Message (707) 5-HORSES Fax: (707)942-0915 Website: www.equi-ed.org Email infoequied@aol.com

RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT *To be completed annually*

NAME: _____ Date: _____
 DATE OF BIRTH _____ AGE _____ SEX _____
 HEIGHT _____ WEIGHT _____ PULSE _____ B.P. _____
 DIAGNOSIS _____
 CAUSE _____
 MEDICATION (type, purpose, dose) _____

If Downs-Syndrome, Atlanto-Axial Subluxation? Yes _____ No _____
 Cervical X-Ray for Atlanto-Axial Subluxation: Positive _____ Negative _____ X-Ray Date: _____

Tetanus Shot: Yes _____ No _____ Date _____

Please indicate if the client has, or has a history of, the following secondary conditions by checking yes or no.
 If YES, please include COMPLETE information pertaining to the problem.

Secondary Condition	No	Yes	If Yes, or History of, Describe
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			
Allergies			
Cardiac			
Circulatory			
PVD			
Postural Hypotension			
Hemophilia			
Pulmonary			
Asthma/COPD			
Neurological			
Seizures			
Controlled			Type:
Date of Last Seizure			
Hydrocephalus			
Shunt			*Revisions
Sensory Loss			
Pain			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing Joints			
Dislocating Joints			
Laminectomy/Fusion			
			Page 1 of 2 Medical History and Physician's Statement

Secondary Condition	No	Yes	If Yes, or History of, Describe
Skeletal Continued . . . Scoliosis-Degree/Type/Brace			
Date of Last X-Ray			
Kyphosis/Lordosis			
Degree/Type			
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Heterotrophic Ossification			
Joint Diseases			
Cranial Defects			
Fractures			Location? Healed?
Other			

MEDICAL HISTORY

Please describe any medical problems not indicated above:

Please indicate special precautions:

MOBILITY STATUS

Ambulatory? Yes _____ No _____ If no, describe _____

PROSTHETICS/ORTHODONTICS:

Type	Purpose
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Type	Purpose
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Please describe any additional information that might help us work with this student.

****PHYSICIAN STATEMENT:** In my opinion this patient can participate in supervised equestrian activities. However, I understand that the therapeutic riding program will weigh the medical information above against the existing precautions, contraindications or other established guidelines.

Physician Name (please print) _____

Physician Signature _____ **Date** _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Phone (_____) _____ **Email:** _____

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability-include neurologic symptoms
Coxa Arthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Age-under 4 years
Indwelling Catheters
Medications-i.e. photosensitivity
Poor Endurance
Skin Breakdown