

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S RELEASE

To be filled out by participant's physician. This release must be received by Forward Stride 3 days prior to first class.

Rider: _____ DOB: _____ Height: _____ Weight: _____ Sex: **M F**

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: + -

Neurological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's ability/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other: _____ License/UPIN Number: _____

Address: _____ Phone: _____

Signature: _____ Date: _____