Equi★Star, Inc.
Horseback Riding Center

Rider's Medical History & Physician's Statement

This form must be completed annually by attending physician before participant is able to ride in any session And must be submitted two (2) weeks before scheduled session.

Name	DOB	**Age ***
Address	City, Zip	
Parent/Guardian	Home Phone	
Diagnosis	Date of Onset	

**** minimum age of 3 ½ to ride***

For persons with Down Syndrome:

- Negative cervical X-ray for Atlantoaxial Instability X-ray date: _____
- Negative for clinical symptoms of Atlantoaxial Instability

Tetanus shot: • Yes • No Date of tetanus shot: _____

Seizure type: _____ Controlled: • Yes • No

Date of last seizure: _____ ***MUST*** be free of atonic or drop seizures for 12 months.

Medications: _____

Height: _____ Weight: _____
maximum weight limit of 200 lbs

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

AREAS	*YES*	*NO*	*COMMENTS*
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility:	• Yes	• No	Independent Ambulation
	• Yes	• No	Crutches
	• Yes	• No	Braces
	• Yes	• No	Wheelchair

Please indicate any special precautions: _____

_____

These following conditions, if present, may also represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree. Equi★Star may want to call rider's physician to discuss any health issues Equi★Star feels may be contradictive.

ORTHOPEDIC
Spinal fusion
Spinal instabilities/abnormalities
Atlantoaxial instabilities
Scoliosis
Kyphosis
Lordosis
Osteoporosis
Coxas arthrosis
Coxas arthrosis
Heterotopic ossification
Osteogenesis imperfecta
Cranial deficits
Spinal orthoses
Internal spinal stabilization devices

MEDICAL/SURGICAL
Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral vascular disease
Hemophilia
Hypertension
Serious heart condition
Stroke (cerebrovascular accident)

NEUROLOGIC
Hydrocephalus/shunt
Spina bifida
Thethered cord
Chiari II malformation
Hydromyelia
Paralysis due to spinal injury
Seizure disorders

SECONDARY CONCERNS
Behavior problems
Age under 2 years
Age 2 – 4 years
Acute exacerbation of chronic disorder
Indwelling catheter
Pain/insulin pumps

_____

_____

_____

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 abilities or limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc) in the implementing of an effective equestrian program.

Physician Name: _____
(please print)

Physician Signature _____

Address _____
(city, zip)

Phone _____ Date _____