



Participants Medical History

Date: _____

Dear Health Care Provider: _____

Your patient, _____
(Participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. 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 Deficits

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Medical/Psychological

Allergies Fire Settings

Animal Abuse Hemophilia

Cardiac Condition Medical instability

Physical/Sexual/Emotional Abuse Migranes

Blood Pressure Control PVD

Dangerous to self or others Exacerbations of medical conditions (i.e. RA, MS) Respiratory Compromise

Recent Surgeries Substance Abuse

Thought Control Disorders Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equinassisted activities, please feel free to contact the center.

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