

Physician Information Form

Please mail to: Northland Therapeutic Riding Center, P.O. Box 1267, Kearney, MO 64060

Participant's Medical History and Physician's Statement (To be completed by physician.)

Participant: _____

DOB: _____ Height: _____ Weight: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____

Controlled: Yes ___ No ___ Date of Last Seizure: _____

Shunt Present: Yes ___ No ___ Date of Last Revision: _____

Special Precautions/Needs: _____

Mobility:

Independent Ambulation: Yes ___ No ___

Assisted Ambulation: Yes ___ No ___

Wheelchair: Yes ___ No ___

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:

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

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

Physician's Name: _____

Physician's Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date: _____