Due West Therapeutic Riding Center
MEDICAL EVALUATION and SIGNED STATEMENT

This form must be completed and signed by a health care professional and must be updated annually, or more frequently if need-
The following conditions, if present, may represent **precautions or contraindications** to therapeutic horseback riding. Therefore, please note if any of these conditions are present, and to what degree.
Please be as specific as possible so tat we may best serve the participant's needs.

Participant: _____

Date of birth: _____ **Height:** _____ **Weight:** _____

Primary diagnosis: _____

(Circle conditions that are present and add specifics below.)

Orthopedics	**Medical**	**Neurologic**
Spinal Fusion	Allergies	Hydrocephalus/shunt
Spinal Instabilities/Abnormalities	Cancer	Tethered Cord
Atlantoaxial instabilities	Poor endurance	Chiari II Malformation
Scoliosis (>30, riding is contraindicated)	Recent Surgery	Hydromyelia
Kyphosis	Diabetes	Paralysis due to spinal cord injury
Lordosis	Peripheral Vascular Disease	Seizure Disorders
Hip Subluxation and Dislocation	Varicose Veins	
Osteoporosis	Hemophilia	

Secondary Concerns:		
Pathologic Fractures	Hypertension	Behavior Problems
Coxas Arthosis	Serious Heart Condition	Age under two years
Heterotopic Ossification		Acute exacerbation of chronic disorder
Cranial Deficits		Indwelling catheter (contraindication for females)
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Other Condition(s) not listed above: _____

Please indicate specifics for all existing health conditions, including degree of conditions such as scoliosis and osteoporosis, type of behavior problems, recent surgeries, type of seizures, location of catheters, ect:

_____

_____

_____

For participants with Down Syndrome Only

Please note:

Due to the nature of equine activities, including horseback riding, participants with Down Syndrome must have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI).

Please *provide* the following information:

Annual neurologic exam for AAI: [ ] Negative … Date of Exam _____

Does the participant have a health concern or surgeries in any of the following areas? If yes, please explain:

Auditory _____

Visual _____

Speech _____

Cardiac _____

Circulatory _____

Pulmonary _____

Neurological _____

Muscular _____

Orthopedic _____

Allergies _____

Learning Disabilities _____

Cognitive _____

Mental or Psychological Impairment _____

Other: _____

Please describe any concerns or special medical or physical precautions or adaptations needed:

_____

_____

_____

_____

_____

HEALTH CARE PROVIDER'S STATEMENT

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Due West Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Due West Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation and implementation of an effective program. Orders: Evaluate and treat [ ] one [ ] two sessions per week throughout the next 12 months.

Health Care Provider Name _____ **Title** _____

Office Address _____ **City** _____ **State** _____

License/UPIN Number: _____ **Phone:** _____

REQUIRED:

Health Care Provider Signature _____ **Date** _____