# Rider's Medical History and Physician's Statement

Please give to your doctor to complete and sign.

Please complete all sections
Name: _____ Date of Birth:_____
Address:_____
Name of Parent/Guardian:_____
Diagnosis:_____ Date of Onset:_____
Height_____ Weight_____
☐ ***For persons with Down Syndrome:***
❑ ***Negative Cervical X-ray for Atlantoaxial Instability. X-ray date***_____
❑ ***Negative for clinical symptoms of Atlantoaxial Instability***
Tetnus Shot: ❑Yes ❑No Date_____
Shunt: ❑Yes ❑No
**Seizures:** Type _____ Controlled_____ Date of last seizure_____
Medications:_____

**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: Independent Ambulation ❑Yes ❑No Crutches ❑Yes ❑No Braces ❑Yes ❑No
Wheelchair ❑Yes ❑No Please indicate any special precautions:_____
_____

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/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_____ State_____ Zip_____