CAROUSEL THERAPEUTIC RIDING

Date: _____

Dear Health Care Provider:

Your patient, _____
(*Participant's Name)*

is interested in participating in supervised horseback riding and equine activities. In order to safely provide this service, Carousel Therapeutic Riding and North Jersey Equestrian Center (collectively, the Center) requests that you complete and update this Medical History and Physician's Statement. In addition to this, you may also provide the Center with any documentation that you deem useful/ necessary in regards to your patient. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note that the provided list is not intended to be exhaustive or limited in any way. Kindly note whether any of these conditions are present, to what degree and/or whether we should be made aware of any other conditions not identified herein.

Orthopedic
Atlantoaxial Instability (include Neurological Symptoms)
Coxarthrosis
Cranial Defects
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

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological/Social
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self and/or Others
Exacerbations of Medical Conditions (ie. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
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, please feel free to contact me.

Warm Regards,

Lucy Silvestri, Program Director
1 Carlson Place
Pompton Plains, New Jersey 07444

Medical History and Physician's Statement

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications/ Allergies to Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of Last Revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Yes	No	COMMENTS
Allergies			
Auditory			
Balance			
Cardiac			
Circulatory			
Cognitive			
Emotional/Psychological			
Immunological			
Integumentary/Skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile Sensation			
Visual			
Other			

Given the above diagnosis/medical information, this person is **not** medically precluded from participating in horseback riding and equine-assisted activities and/or therapies. I understand that PATH INTL. center will weigh the medical information given against the existing precautions and contraindications.

Name/Title/ License/UPIN Number: _____

Signature: _____ Date: _____

Address and Phone: _____