



Equi Star Therapeutic Riding Center, Inc.

2012 Rider's Medical History & Physicians Statement (to be completed annually by attending physician)

Name	DOB	Age *
Address	City, Zip	
Parent/Guardian	Home Phone	
Diagnosis	Date of Onset	

**minimum age of 3 1/2 to ride*

For persons with Down Syndrome:

Negative cervical X-ray for Atlantoaxial Instability

X-ray date: _____

Negative for clinical symptoms of Atlantoaxial Instability

Tetanus shot: Yes No

Date of tetanus shot: _____

Seizure type: _____

Controlled: Yes No

Date of last seizure: _____

Medications: _____

Height: _____

Weight: _____

maximum weight limit of 200 lbs

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: Yes No Independent Ambulation
 Yes No Crutches
 Yes No Braces
 Yes No Wheelchair

Please indicate any special precautions: _____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

ORTHOPEDIC

Spinal fusion
 Spinal instabilities/abnormalities
 Atlantoaxial instabilities
 Scoliosis
 Kyphosis
 Lordosis
 Osteoporosis
 Coxas arthrosis
 Coxas arthrosis
 Heterotopic ossification
 Osteogenesis imperfecta
 Cranial deficits
 Spinal orthoses
 Internal spinal stabilization devices

MEDICAL/SURGICAL

Allergies
 Cancer
 Poor endurance
 Recent surgery
 Diabetes
 Peripheral vascular disease
 Hemophilia
 Hypertension
 Serious heart condition
 Stroke (cerebrovascular accident)

NEUROLOGIC

Hydrocephalus/shunt
 Spina bifida
 Thethered cord
 Chiari II malformation
 Hydromyelia
 Paralysis due to spinal injury
 Seizure disorders

SECONDARY CONCERNS

Behavior problems
 Age under 2 years
 Age 2 – 4 years
 Acute exacerbation of chronic disorder
 Indwelling catheter

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 or 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, zip)

Phone _____ Date _____