## **DEBE SER COMPLETADO Y FIRMADO POR EL DOCTOR!!**

## Historial médico del participante y Declaración del Médico

Tactile Sensation  Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain	Participant:		D	OB:	Height:	Weight:
Diagnosis:						
Medications:						
Medications:	Past/Prospective Surgeries:					
Controlled: Y N Date of Last Seizure:   Changes in frequency and seizure type: Y N If yes, Please Describe:						
Changes in frequency and seizure type: Y N If yes, Please Describe:					Date of Last S	Seizure:
Implanted Vagal Stimulator: Y N Date of last revision:  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:  Tetanus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:					escribe:	
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:  Tetanus Shot: Yes No Date  For those with Down Syndrome:  AtlantoDens Interval X-rays, date: Result: +  Neurologic Symptoms of AtlantoAxial Instability:  Please indicate current or past special needs in the following systems/areas, including surgeries:  Y N Comments  Auditory  Visual  Tactile Sensation  Speech  Cardiae  Circulatory  Integumentary/Skin Integumentary/Sk						
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N Braces/Assistive Devices:  Tetarus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:Result: + -  Neurologic Symptoms of AtlantoAxial Instability:  Please indicate current or past special needs in the following systems/areas, including surgeries:  Y N Comments  Auditory  Visual  Tactile Sensation  Speech  Cardiac  Circulatory  Integumentary/Skin  Immunity  Pulmonary  Neurologic  Muscular  Balance  Orthopedic  Allergies  Learning Disability  Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against existing precautions and contraindications. I concur with a review of this person's abilities flinitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name Title:	_	N Date o	f last revision:			
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N Braces/Assistive Devices:  Tetanus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:	Special Precautions/Needs:					
Braces/Assistive Devices:  Tetanus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:	<u></u>					
Braces/Assistive Devices:  Tetanus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:	Mobility: Independent Ambul	ation Y N	Assisted An	nbulation Y N	Wheelchair	Y N
Tetanus Shot: Yes No Date  For those with Down Syndrome: AtlantoDens Interval X-rays, date:	-					1 11
For those with Down Syndrome: AtlantoDens Interval X-rays, date:						
Neurologic Symptoms of Atlanto-Axial Instability:  Please indicate current or past special needs in the following systems/areas, including surgeries:  Y N Comments  Auditory  Visual  Tactile Sensation  Speech  Cardiac  Circulatory  Integumentary/Skin  Immunity  Pulmonary  Neurologic  Muscular  Balance  Orthopedic  Allergies  Learning Disability  Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the plementation of an effective equine activity program.  Mame Cittle:						
Please indicate current or past special needs in the following systems/areas, including surgeries:    Y	-			A-rays, uate:	Kes	uni. + -
Auditory Visual Tactile Sensation Speech Cardiae Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, ec.) in the implementation of an effective equine activity program.  MD DO NP PA Other				systems/areas, includi	ng surgeries:	
Auditory Visual Tactile Sensation Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Namoe/Title:		_	1			
Visual Tactile Sensation Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title:	Auditory	-	-,			
Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title: MD DO NP PA Other Signature:	Visual					
Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title: MD DO NP PA Other Signature:	Tactile Sensation					
Cardiac  Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title:  MD DO NP PA Other  Jate:  Jate:  Address:  Address:						
Circulatory Integumentary/Skin Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title:  MD DO NP PA Other  Signature:  Date:  Address:  Address:	•					
Immunity Pulmonary Neurologic Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program. Name/Title: MD DO NP PA Other Signature: Date: Date: Address:	Circulatory					
Pulmonary  Neurologic  Muscular  Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:  MD DO NP PA Other  Signature:  Date:  Date:  Address:	Integumentary/Skin					
Neurologic  Muscular  Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Immunity					
Muscular  Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:  MD DO NP PA Other  Signature:  Date:  Address:  Address:	Pulmonary					
Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:  MD DO NP PA Other  Signature:  Date:  Address:  Address:	Neurologic					
Orthopedic  Allergies  Learning Disability  Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:MD DO NP PA Other  Signature:MD DO NP PA Other  Date:  Address:	Muscular					
Allergies  Learning Disability  Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:  MD DO NP PA Other  Signature:  Date:  Address:	Balance					
Learning Disability  Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Orthopedic					
Cognitive  Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Allergies					
Emotional/Psychological  Pain  Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Learning Disability					
Pain Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Cognitive					
Other  To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title: MD DO NP PA Other  Signature: Date:  Address:	Emotional/Psychological					
To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title:	Pain					
Intl. center will weigh the medical information above against 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, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.  Name/Title: MD DO NP PA Other  Signature: Date:  Address:	Other					
Address:	Intl. center will weigh the medical abilities/limitations by a licensed/equine activity program.	information above credentialed health	e against existing professional (e.g	precautions and contraindi . PT, OT, SLP, Psychologi	cations. I concur windst, etc.) in the impler	th a review of this person's mentation of an effective
	Signature:				Date:	
Phone: ()	Address:					
	Phone: ( )					