Riverwood Therapeutic Riding Center
(336) 922-6426 phone/fax
6825 Rollingview Drive
Tobaccoville, NC 27050

MUST BE COMPLETED AND SIGNED BY DOCTOR!!!

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

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

Changes in frequency and seizure type: Y N ***If yes, Please Describe:*** _____

Implanted Vagal Stimulator: Y N ***If yes, Date of Implant:*** _____

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			
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 assisted services. 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: _____

Phone: (_____) _____