Access Equestrian

**Mailing Address:**
P.O. Box 413
Valhalla, NY 10595
(914) 234-9000
info@accessequestrian.org

Date: _____

Dear Health Care Provider:

Your patient _____ is interested in participating in supervised equine activities.

In order to safely provide this service, our program requests that you complete/update the enclosed Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**
Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossifications/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Join 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 – e.g. Photosensitivity
Poor Endurance
Skin Breakdown

**Medical/Psychological**
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions – e.g. RA, MS
Fire Setting
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's participation in equine activities, please feel free to contact our program.

## PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Name: _____ DOB: _____ Height: _____ Weight:_____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizures? Y N Type: _____ Controlled: Y N Date of Last Seizure:
_____
Shunt Present? Y N Date of Last Revision: _____
Special Precautions (Diet/Needs/Allergies): _____
_____ May participate in all activities _____ May participate except
for:_____
Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices: _____
***For those with Down Syndrome:*** AtlantoDens Interval X-rays Date: _____ Result: + --
Neurological Symptoms of AtlantoAxial Instability: _____

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

| | Y | N | Comments: |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

### IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

**If you prefer to provide the requested information on your own medical form, we will accept that as long as the top and bottom sections of this form are also completed, signed and dated and stapled to your form.**

Given the above diagnosis and medical information this person is not medically precluded from participation in equine activities. I understand that the adaptive riding program will weigh the medical information above against existing precautions and contraindications. Therefore I refer this person to the program for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____