Dear Health Care Provider,

One of your patients is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine-assisted activities and therapies. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Precautions and/or Contraindications for Therapeutic Riding Activities:

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
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/Hydromelia

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

Medical
Allergies
Blood Pressure Control
Cardiac Condition
Exacerbations of medical conditions (i.e. RA, MS)
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Weight Control Disorders

Psychological
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Fire Settings
Substance Abuse
Thought Control Disorders

Thank you for your assistance! If you have questions about Equine Assisted Activities and Therapies or the services provided at Therapeutic Riding At Centenary (TRAC), please contact Karen Brittle, Director of TRAC, at karen.brittle@centenaryuniversity.edu or (908)852-1400, ext. 2174.

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Therapeutic Riding At Centenary
T.R.A.C.

CENTENARY UNIVERSITY

Participant's Medical History & Physician's Statement

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

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Purpose of 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: _____

For those with Down Syndrome - Result of neurologic exam to check for symptoms of Atlantoaxial Instability:

_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH Intl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( )_____ License/UPIN Number: _____