Cincinnati Therapeutic Riding and Horsemanship

Participant's Medical History & Physician's Statement 2019

THIS FORM MUST BE COMPLETED ANNUALLY TO BE CONSIDERED FOR PARTICIPATION

Participant Information (to be filled out by Participant/Parent/Caregiver)

Applicant's Name: _____ Nickname: _____

Age: _____ (minimum age: 2 1/2 - HPOT; 5 - Recreational Riding) Birthdate: _____ Gender: _____

Address: _____
Street City State Zip

Parent/Guardian/Caregiver Name(s): _____ Phone: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____

Participant Medical Information (to be filled out by Physician)

Diagnosis:_____

Weight: _____lbs. (175 lb. limit)

Height: _____

Tetanus Shot: ___ No ___ Yes - Date: _____

Normal Blood Pressure: _____

Normal Temperature: _____

Complete both sections for participants with Down syndrome:

Neurologic symptoms of Atlantoaxial Instability

_____ Exam date _____negative _____ positive

!!Neurologic exam must be completed every calendar year!! (2016)

Cervical X-Ray for Atlantoaxial Instability

_____ X-ray date *(most recent)*

_____negative _____ positive

Medications: _____

Past medical history, problems, and/or surgeries

	Yes	No	Comments
Auditory	_____	_____	_____
Visual	_____	_____	_____
Speech	_____	_____	_____
Cardiac	_____	_____	_____
Circulatory	_____	_____	_____
Pulmonary	_____	_____	_____
Neurological	_____	_____	_____
Muscular	_____	_____	_____
Orthopedic	_____	_____	_____
Allergies	_____	_____	_____
Learning Disability	_____	_____	_____
Mental Impairment	_____	_____	_____
Psychological Impairment	_____	_____	_____
Seizure Disorder	_____	_____	_____
Controlled	_____	_____	Date of last seizure: _____

Mobility Status

___ Independent _____ Walker _____ Cane _____ Crutches _____ Wheelchair

Transfer Ability: _____

Completed Form Can Be Returned Directly To CTRH - Secure Fax 844-716-2708

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Information for Physician

The following conditions, if present, may represent precautions or contraindications to hippotherapy and/or therapeutic riding. **Please indicate whether these conditions are present and to what degree.**

Orthopedic
Spinal Fusion
Spinal Instabilities / Abnormalities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation / Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices
Atlantoaxial Instability - include neurologic symptoms

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Cardiac Condition
Stroke

Neurologic
Hydrocephalus / Shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns
Behavior Problem
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

Physician's Statement for All Participants:

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Physician's Name (Please Print): _____ Phone: _____

Physician's Signature: _____ Date: _____

Address: _____
Street City State Zip

Prescription for Hippotherapy Participants Only:

Prescription for occupational, speech therapy, and physical therapy utilizing hippotherapy as a therapeutic strategy. Functional goals will integrate improvement with balance, strength, posture, communication, and activities of daily living.

Physician's Signature: _____ Physician's Name: _____

CTRH
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