Participant's Annual Physician's Statement Update

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

Diagnosis: _____ **Date of Onset**: _____

Past/Prospective Surgeries: _____

Medications: _____

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

** If there has been recent seizure activity, please complete MTR's Seizure Statement and include with the completed Rider Application Packet*

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 for Atlantoaxial Instability: □ Present □ Absent

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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 the 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: ( ) _____ License/UPIN Number: _____