Participant's Medical History & Physician's Statement

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 seizure activity in the last 10 years, 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

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			

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: _____