Renew Therapeutic Riding Center

5080 146th Ave, Holland, MI 49423

https://renewtrc.org

PARTICIPANT'S MEDICAL HISTORY/PHYSICIAN RELEASE

(Health Care Provider must complete and sign this form for each student)

Participant: _____ Date: _____

Address: _____

Primary Diagnosis: _____ ICD Code: _____

Onset (please check one): ☐ Birth / ☐ Childhood / ☐ Adolescence / ☐ Adult

Secondary: _____ ICD Code: _____ Tertiary: _____ ICD Code: _____

DOB: _____ Height: _____ Weight: _____ Tetanus Shot: ☐ no / ☐ yes Date: _____

PLEASE LIST ALL CURRENT MEDICATIONS

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____

Seizure type: _____ Controlled? _____ Date of last seizure: _____

Ambulatory: ☐ Yes / ☐ No

Uses: ☐ Crutches / ☐ Braces / ☐ Cane / ☐ Walker ☐ Wheelchair

Special precautions needed with this student: _____

_____

Please indicate current or past difficulties in the following systems/areas (including surgeries):

System/Area	Yes	No	Comments
Allergies (incl. asthma)			
Auditory			
Balance			
Cardiac			
Circulatory (incl. hemophilia)			
Cognitive problems			
Emotional/psychological			
Immunity			
Integumentary/skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Speech			

System / Area	Yes	No	Comments
Tactile sensation			
Visual (including glasses)			
Other			

The following may suggest precautions or contraindicate therapeutic horsemanship:

Orthopedic	Medical / Psychological
Atlantoaxial Instability - include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Cancer
Heterotopic Ossifications / Myositis Ossificans	Cardiac Condition
Internal Spinal Stabilization Device	Physical / Sexual / Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Pathological Fractures	Dangerous to Self or Others
Spinal Join Fusion/Fixation	Exacerbations of medical conditions (e.g. MS, RA)
Spinal Joint Instability/Abnormalities	Fire-setting
Neurologic	Hemophilia
Hydrocephalus / Shunt / Shunt revision	Medical Instability
Paralysis due to Spinal Cord Injury	Migraines
Seizures	Peripheral Vascular Disease
Spina Bifida / Chiari II Malformation / Tethered Cord / Hydromyelia	Respiratory Compromise
Stroke	Recent Surgeries
Other	Substance Abuse
Age —Under 4 years for therapeutic riding	Thought Control Disorders
Indwelling catheters / medical equipment	Weight Control Disorders
Medication side effects (e.g. photosensitivity)	
Poor endurance	
Skin breakdown	

Please indicate if any of the above conditions are present and to what degree.

_____

_____

_____

******FOR PERSONS WITH DOWN SYNDROME******

Neurological symptoms of Atlantoaxial Instability? ☐ Yes / ☐ No

Date of neurological exam: _____

NEUROLOGIC EXAM RESULTS MUST BE UPDATED ANNUALLY AND FORM MUST BE SIGNED BY A LICENSED PHYSICIAN.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh this medical information against the existing precautions and contraindications. Therefore, I refer this person to the therapeutic riding center for ongoing evaluation to determine eligibility for participation. Name (Please print): _____ Title: MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____