EAST CENTRAL INDIANA
Therapeutic Riding, Inc.
Contact: Elise Matthews
8920 W. C.R. 500 N.
Muncie, IN 47304
(765) 730-2747

Participant's Medical History and Physician's Statement

Participant:_____

DOB:_____ Age:_____ Height:_____ Weight:_____ Female

Address:_____

Diagnosis:_____ Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____

Seizure Type:_____ Controlled: 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: AtlantoDens Interval X-rays, date:_____ Results: + --

Neurologic Symptoms of AtlantoAxial Instability:_____

Please indicate on the next page the current or past difficulties in the following systems/areas, including surgeries:

	Y	*N*	*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 equestrian activities. However, I understand that the therapeutic riding 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, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name:Title:_____ MD DO NP PA Other:_____

Signature:_____ Date:_____

Address:_____

Phone:_____ License/UPIN Number:_____