



E A S T C E N T R A L I N D I A N A

Therapeutic Riding, Inc.

Contact: Elise Matthews
8920 W. C.R. 500 N.
Muncie, IN 47304
(765) 730-2747

Date: _____

Dear Physician:

Your patient, _____ (participant's name)
is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered
Cord/Hydromyelia

Other

Age – under 4 years old
Indwelling Catheters
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Danger to Self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
East Central Indiana Therapeutic Riding Inc.

ECITRI - East Central Indiana Therapeutic Riding Inc. – S.P.U.R. – Special People United in Riding

* www.ECITRI.org *