Horsin' Around

Equine-**Assisted Therapies for Special Needs Individuals**
501(c)3 Non-Profit Organization 56-2286412
2875 A Fort Argyle Rd, Bloomingdale, GA 31302
PO Box 13524, Savannah, GA 31416
www.horsinaround.org / horsinaroundgeorgia@gmail.com / 912-748-7917

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete or update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. 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 Ossiffication/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractions
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida
Chiari II Malformation
Tethered Cord
Hydromyelia

Other
Age - under 4 years
Indwelling Catheters
Medications - i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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

Sincerely,

Erin Dunn, DPT, PT
President
PATH International Registered Instructor

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Participant's Medical History & Physician's Statement

Participant: _____DOB: _____ Height: _____ Weight:

Address:

Diagnosis: _____Date of Onset:

Past/Prospective Surgeries:

Medications:

Seizure Type: _____Controlled: Y 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's Syndrome: AtlantoDens Interval x-rays, date: _____Result: + -

Neurologic Symptoms of AtlantoAxial Instability:

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Please indicate current or past special needs 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			
Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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To my knowledge, there is no reason why this person cannot participate in supervised equestrian 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, SPL, 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: