



Calvin Center
 Therapeutic Riding Program
 13550 Woolsey Road
 Hampton, GA 30228
 770-946-4276
 www.calvincenter.org

Rider's Medical History and Physician's Statement

To be completed by applicant's physician. Please type or print. Use black or blue ink.

Applicant's Name _____ Date of Birth _____ Gender _____

Parent / Guardian _____

Address _____

City _____ State _____ Zip _____

Diagnosis _____ Age of onset _____

Height _____ Weight _____

Please list current and past special needs in the following areas by checking YES or NO. If YES, please include complete information, including surgical history, pertaining to the situation. Attach an additional page if needed.

SPECIAL NEED	YES	NO	IF YES, OR HISTORY OF, DESCRIBE	
Auditory Impairment				
Attention Deficit / Hyperactivity				
Learning Disability				
Mental Impairment				
Psychological Impairment				
Speech Impairment				
Visual Impairment				Glasses / Contacts:
Allergies				Type of Reaction
Cardiac				
Circulatory				
Gastrointestinal				
Gastrostomy				
Pulmonary				
Asthma / COPD				
Neurological				
Hydrocephalus/ Shunt				
Balance Impairment				
Sensory Loss				
Hypertonicity				
Hypotonicity				
Urological				
Incontinence				
Indwelling Catheter				
Muscular				
Contractures				
Skeletal				
Spinal Column Injury				
Subluxing or Dislocating Joints				
Laminectomy				
Spinal Fusion				
Scoliosis – Degree / Type / Brace/ Last X-Ray				
Spondylolisthesis				
Osteoporosis				
Heterotrophic Ossification				
Fractures			Location?	Healed?
Other				

For Persons with Down Syndrome:

Cervical X-ray for Atlantoaxial Instability:

Positive _____ Negative _____ X-Ray Date _____

Current clinical exam on _____ (date) reveals no symptoms symptoms of Atlantoaxial Instability.

Comments: _____

Medications: (type, purpose, dose): _____

Seizure Type: _____ Controlled _____

Date of Last Seizure _____ Comments _____

Mobility Status:

Ambulatory: _____yes _____no Assistive Device: _____cane _____crutches _____walker

Prosthetic/Orthotics: _____yes _____no If yes, please specify _____

Please indicate special precautions: _____

IN MY OPINION, THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE SIGNED.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ UPIN or License # _____

Physician's Address _____ City _____ State _____ Zip _____

Physician's Telephone Number _____

****Only signatures of MD's or DO's are accepted*

INFORMATION FOR PHYSICIANS

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 or other cervical instability – including neurologic symptoms
- Activity limiting arthritis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans (activity limiting)
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion/Fixation
- Spinal Instability/Abnormalities

- Hemophilia
- Medical Instability
- Migraines
- PVD Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

Neurologic

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

Other

- Age – under 4 years'
- Indwelling Catheters
- Medications - photosensitivity, balance, memory, dizziness, judgement
- 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
- Fire Settings

