



## 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 Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result:  +  --  
 Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

***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 Disability     |   |   |          |
| Cognitive               |   |   |          |
| Emotional/Psychological |   |   |          |
| Pain                    |   |   |          |
| Other                   |   |   |          |

To my knowledge, there is no reason why this person cannot participate in equine assisted activities. However, I understand that Horseplay will weigh the medical information above against the existing precautions and contraindications.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (     ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_