THERAPEUTIC RIDING 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 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:

Neurologic Symptoms of Atlantoaxial Instability: ____ Present ____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	**N**	**Comments**
Auditory	___	___	_____
Visual		___	___ _____
Tactile Sensation	___	___	_____
Speech	___	___	_____

Cardiac ___ ___ _____

Circulatory ___ ___ _____ Integumentary/Skin

___ ___ _____

LB Therapeutic Medical Form (3-7-14)

	Y	N	Comments
Immunity	___	___	_____
Pulmonary	___	___	_____
Neurologic	___	___	_____
Muscular	___	___	_____
Balance	___	___	_____
Orthopedic	___	___	_____
Allergies	___	___	_____
Learning Disability		___	___ _____
Cognitive	___	___	_____
Emotional/Psychological	___	___	_____
Pain	___	___	_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that The Stables at Le Bocage will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The Stables at Le Bocage, a member of PATH International, for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____

Signature:_____ Date:_____

Address:_____

Phone: (____)_____ License/UPIN Number:_____

LB Therapeutic Medical Form (06/08/2021)