Lutheranch
342 McGinnis Road, Lot 2
Tallapoosa, Georgia 30176

404-583-4591
www.luthernach.org

# Rider's Medical History and Health Care Provider's Statement

To be completed by applicant's health care provider (MD, DO, NP or LPN). 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<br>Gastrostomy | | | |
| Pulmonary<br>Asthma / COPD | | | |
| Neurological<br>Hydrocephalus/ Shunt | | | |
| Balance Impairment | | | |
| Sensory Loss | | | |
| Hypertonicity | | | |
| Hypotonicity | | | |
| Urological<br>Incontinence | | | |
| Indwelling Catheter | | | |
| Muscular<br>Contractures | | | |
| Skeletal<br>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**

Current clinical exam on _____(date) reveals __*no symptoms*__*symptoms* of Atlantoaxial Instability.
Comments: _____
_____

**Medications:** (type, purpose, dose, list additional on back of form):_____
_____

**Seizure Type (if applicable):** _____ 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 (CIRCLE ONE):**

SUPERVISED GROUND AND/OR MOUNTED EQUESTRIAN ACTIVITIES.

SUPERVISED EQUESTRIAN GROUND ACTVIVITIES ONLY

I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR ONE YEAR FROM THE DATE SIGNED.

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (Please Print)_____ UPIN or License # _____

Health Care Provider's Address _____City _____State_____ Zip_____

Health Care Provider's Telephone Number _____

******Only signatures of MD'S, DO'S, LPN'S OR NP'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

**Medical/Psychological**
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
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