



Participant's Medical History & Physician's Statement

TO BE COMPLETED ANNUALLY

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

City State Zip

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Seizures? Yes No Type: _____ Controlled? Yes No Date of Last Seizure: _____

Special Precautions/Needs: _____

Mobility: Independent ___ Cane ___ Crutches ___ Braces ___ Walker ___ Wheelchair ___

For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____ Results: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Systems/Areas	Yes	No	Comments:
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Medications			
Other			

Please See Other Side - Signature Required

Information for Physician

The following conditions may suggest precautions and contraindications to equine assisted activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic

Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification
Joint subluxation/dislocation
Kyphosis
Lordosis
Myositis Ossificans
Osteoporosis
Pathologic Fractures
Scoliosis
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Spinal Orthoses
Spinal Stabilization Devices (Internal)

Neurologic

Chiari II malformation
Hydrocephalus/Shunt
Hydromyelia
Seizure Disorders
Spina Bifida
Tethered Cord

Medical

Allergies
Blood Pressure Control
Heart Conditions
Hemophilia
Hypertension
Medical Instability
Migraines
PVD
Recent Surgeries
Respiratory Compromise
Stroke
Varicose Veins

Other

Acute exacerbation of chronic disorder
Age - less than 4 years
Behavior Problems
Indwelling Catheters
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. However, I understand that Equul Access, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Equul Access, Inc. for ongoing evaluation to determine eligibility for participation.

Physician Name (Please Print): _____

Signature: _____ Date: _____

Address: _____

City

State

Zip

Phone: (_____) _____

Thank you very much for your assistance. For more information on equine assisted activities, please feel free to contact:

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