Date: __________________

Dear Health Care Provider:

Your patient, _______________________________________, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician’s Statement Form. Please note that 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 Instability – include neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

**Neurologic:**
- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**Other:**
- Age – under 4 years
- Indwelling Catheters/Medical Equipment
- Medications – i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

**Medical:**
- Allergies
- Cardiac Condition
- Blood Pressure Control
- Exacerbations of medical conditions (i.e. RA, MS)
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Weight Control Disorders

**Psychological:**
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Dangerous to self or others
- Fire Settings
- Substance Abuse
- Thought Control Disorders
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:

<table>
<thead>
<tr>
<th>System</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tactile Sensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac/Circulatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary/Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic/Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH Intl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for ongoing evaluation to determine eligibility for participation.

Name/Title: ________________________________________   MD   DO   NP   PA   Other ___________
Signature: ________________________________________________________________________________     Date: ______________
Address: _____________________________________________________________
Phone: (_____) ________________     License/UPIN Number: ___________________________