SEND TO PHYSICIAN ONLY COMPLETE IF YOU HAVE A PHYSICAL DISABILITY/ OTHER HEALTH CONCERNS THAT COULD BE CONTRAINDICATIONS TO RIDING

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	**Neurologic**	**Medical/Psychological**	**Other**
Atlantoaxial Instability - include neurologic symptoms	Hydrocephalus/Shunt	Allergies	Age - under 4 years
Coxa Arthrosis	Seizure	Animal Abuse	Indwelling Catheters
Cranial Deficits	Spina Bifida/Chiari II malformation/ Tethered Cord/Hydromyelia	Cardiac Condition	Medical Equipment
Heterotopic Ossification/Myositis Ossificans		Physical/Sexual/Emotional Abuse	Medications - i.e. photosensitivity
Joint subluxation/dislocation		Blood Pressure Control	Poor Endurance
Osteoporosis		Dangerous to self or others	Skin Breakdown
Pathologic Fractures		Exacerbations of medical conditions (i.e. RA, MS)	
Spinal Joint Fusion/Fixation		Fire Settings	
Spinal Joint Instability/Abnormalities		Hemophilia	
		Medical Instability	
		Migraines	
		PVD	
		Respiratory Compromise	
		Recent Surgeries	
		Substance Abuse	
		Thought Control Disorders	
		Weight Control Disorder	

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at (701) 523-6407.

Sincerely,
Robyn Mrnak
Hope and Healing Therapeutic Riding

SEND TO PHYSICIAN

2024 Participant's Consent for Release of Information

I hereby authorize:_____(person or facility) to release information from the records of:
_____(participant's name)
DOB: _____

The information is to be released to Hope and Healing Therapeutic Riding, Robyn Mrnak for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

___Medical History

__Physical Therapy evaluation, assessment and program plan

__Occupational Therapy evaluation, assessment and program plan

__Speech Therapy evaluation, assessment and program plan

__Mental Health diagnosis and treatment plan

__Individual Habilitation Plan (I.H.P.)

__Classroom Individual Education Plan (I.E.P.)

__Psychosocial evaluation, assessment and program plan

__Cognitive-Behavioral Management Plan

_X_ **Attached Participant's Medical History & Physician's Statement, signed & dated**

Other:_____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____Date: _____
Print Name: _____
Relation to Participant:
_____

SEND TO PHYSICIAN

Participant's Medical History and 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:_____.

Neurological Symptoms of AtlantoAxial Instability: _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective activity program.

Name/Title:_____ MD DO NP PA Other:_____

Signature: _____ Date: _____

Address: _____

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