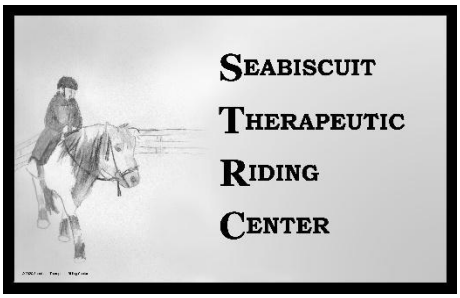

P.O. Box 405
Redwood Valley, CA 95470
(707) 391-3873

Physician Release

Dear Healthcare Provider:

Your patient, _____, is interested in participating in supervised equine activities at Seabiscuit Therapeutic Riding Center.

In order to safely provide this service, our program requests that you complete this Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions or contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

___ Respiratory Compromise

___ Recent Surgeries

___ Substance Abuse

___ Thought Control Disorders

___ Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact our program at (707)391-3873.

PARTICIPANT MEDICAL HISTORY AND PHYSICIAN STATEMENT

Name: _____

DOB: _____

Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Date of Onset: _____

Past/Prospective Surgeries: _____

_____

Medications: _____

Seizures? Y N Type: _____ Controlled? Y N

Date of Last Seizure: _____

Shunt Present? Y N Date of Last Revision: _____

Special Precautions (Diet/Needs/Allergies): _____

_____

___ May participate in <u>all</u> activities.

___ May participate in all activities <u>except for</u>:

_____

Mobility:
Independent Ambulation? Y N
Assisted Ambulation? Y N
Wheelchair? Y N

Braces/Assistive Devices: _____

Please indicate current or past 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		
Integumentary/Skin		
Immunity		
Pulmonary		
Neurologic		
Muscular		
Balance		
Orthopedic		
Allergies		
Learning Disability		
Cognitive		
Emotional/Psychological		
Pain		
Other		

*For those with Down Syndrome:

AtlantoDens Interval X-rays Date: _____ Result: + -

Neurological Symptoms of AtlantoAxial Instability: _____

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide the requested information on your own medical form, we will accept that as long as the top and bottom sections of this form are also completed, signed, dated, and stapled to your form.

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

Name/Title: _____ MD DO NP PA

Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____