MEDICAL HISTORY – To be completed by independent rider or parent/guardian

Name: _____ Date of Birth: _____

Address: _____ Male / Female

Name of Parent / Guardian: _____

Diagnosis: _____ Date of Onset:_____

Tetanus Shot: Yes _____ No _____ Date: _____ Height:_____ Weight:_____

Seizure Type: _____ Controlled: _____ Date of last seizure:_____

Medications:_____

Mobility: (Circle each) Ambulatory–Yes/No Crutches–Yes/No Braces–Yes/No Wheelchair–Yes/No

Special precautions: _____

AREAS	*Yes*	*No*	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory (incl. hemophilia)			
Pulmonary			
Neurological			
Muscular			
Orthopedic(spinal/joint)			
Allergies (asthma)			
Learning Disability			
Mental Impairment			
Psychological Impair. Incl. behavioral			
Other			
Other			

PHYSICIAN RELEASE

Given the above diagnosis and medical information, this person is not medically precluded from participation in therapeutic riding activities. I understand that Horse Feathers Therapeutic Learning Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Horse Feathers Therapeutic Learning Center for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ DATE: _____

Physician's Name (**please print**):_____ Phone: _____

Address/City/Zip: _____

• • • FOR PERSONS WITH DOWN SYNDROME • • • PHYSICIAN MUST COMPLETE THE FOLLOWING• • •

Cervical X-Ray for Atlantoaxial Instability: Positive ____ Negative ____ X-Ray Date _____

Subsequent annual clinical exam (by physician who is knowledgeable in AAI condition) reveals symptoms of Atlantoaxial Instability?: Yes _____ No _____ Date of Exam _____

If participant has experienced seizure activity within the past 12 months, the following SEIZURE EVALUATION FORM is required. Participants or their parents or guardians may wish to consult with their physician when completing the following:

SEIZURE EVALUATION FORM

Instructions: Participants/parent/guardians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Physician Treating Seizures_____ Physician's Phone_____

Type of Seizure (if more than one, please list all types_____

_____

Date of Last Seizure _____Frequency of seizures_____

Duration of Each Seizure_____

Typical Causes of Seizure Activity_____

Seizure activity indicators: (aura, behaviors or manifestations of oncoming seizure activity)_____

_____

After Affect_____

During a seizure, I / my child:

__ May stare briefly (How long?)

__ May walk around

__ May perform aimless activities

__ May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color

__ May experience loss of bladder or bowel control

__ May be confused, have a headache, be fatigued; followed by full return of consciousness

__ Other. Please explain:

Are you / is your child able to know when a seizure may occur? Can you / they express it? What are the signs?_____

_____

Should you / your child experience a seizure while at Horse Feathers Therapeutic Learning Center, beyond employing general first aid, what actions do you suggest we take?

__ Do nothing __ Report observations to parents/guardians immediately

__ Dismount from horse __ Send note home to parent/guardian

__ Allow minutes to rest and reorient __ Other. Please specify:_____

_____

_____

Participant/Parent/Guardian Date _____Date_____