PHONE 248-709-3575 FAX 870-729-8510
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PARTICIPANT MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Participant Name_____ DOB _____ Height_____ Weight _____
Diagnosis: _____ Date of Onset: _____
Medications:_____
Seizure Type: _____ Controlled: Yes _____ No:_____ Date of last seizure: _____
Shunt Present: Yes _____ No _____ Date of last Revision: _____
Special Precautions/Needs:_____
Mobility: Independent Ambulation: Yes ___ No __ Assisted Ambulation: Yes __ No__ Wheelchair: Yes___ No ___
Down Syndrome-Symptoms of Atlanto-Axial Instability?:_____
Type(s) of Therapy indicated: ____Physical Therapy ____Occupational Therapy ____Speech Therapy ___PT, OT & ST

PLEASE INDICATE CURRENT OR PAST DIFFICULTIES IN THE FOLLOWING SYSTEMS/AREAS, INCLUDING SURGERIES:

	YES	NO	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Physician's Statement

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP) and creation of an appropriate plan of care.

Physician's Signature: _____ *Date:* _____
Please print, type or stamp
Physician's Name: _____
Phone: _____

Once complete, please have patient give form to Branded EBTS or fax to **870-729-8510.**