A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

Participant's Medical History & Physician's Statement

Participant:____DOB:__________Height_______Weight_________

Address:____

Diagnosis:____Date of Onset:_________________

Past/Prospective Surgeries:____

Medications:____

Seizure Type:____

Medications:____

SeizureType:____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: ____

PATH International requires that all potential participants with Down syndrome have a medical examination by a licensed physician including a complete neurological exam that shows no evidence of AAI or neurologic symptoms. This information must be noted on the Annual Medical History and Physicians Statement. Thereafter an annual examination from a physician or qualified medical professional stating that the participant's physical exam reveals no signs of AAI or decrease in neurologic function is required for continued participation in any equine assisted activity at Kopper Top.

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

Special Need	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
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 equestrian activities. However, I understand that Kopper Top Life Learning Center, Inc. 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 (eg. PT, OT, SLP, Psychologist, etc.) in the implementation or an effective equine activity program.

Name/Title:____MD DO NP PA Other _____________________________

Signature____Date__________________________________

Address:____

Phone:( )_________________________________ License/UPIN Number____

Client Release Consent for treatment may be withdrawn at any time.