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: _____

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

Special Need	Y	N	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 the NARHA 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
(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Consent for treatment may be withdrawn at any time.