SERENDIPITY EQUINE HAVEN

Where Dreams Are Born and Hopes Are Raised

Participant/Rider/Athlete Medical History

Name: _____ DOB: _____

Parent/Guardian: _____ Relationship: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (_____) _____-_____

Diagnosis: _____ Date of onset:_____ Ht: _____ Wt: _____

** For persons with Down syndrome:

__ Negative cervical x-ray for Atlantoaxial Instability Date of x-ray:_____

__ Negative for clinical symptoms of Atlantoaxial Instability

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

Tetanus shot: Yes_____ No_____ Date: _____

Vaccinations Up to Date and Current: Yes_____ No_____ If no, please explain why: _____

_____

Medications: _____

_____

_____

_____

_____

_____

Allergies: _____

_____

_____

_____

Please indicate if patient has/had a problem and/or surgeries in any of the following areas by checking:

	YES	or NO	If YES, please comment:
Auditory	____	____	_____
Visual	____	____	_____
Speech	____	____	_____
Cardiac	____	____	_____
Circulatory	____	____	_____
Pulmonary	____	____	_____
Neurological	____	____	_____
Muscular	____	____	_____
Orthopedic	____	____	_____
Allergies	____	____	_____
Learning Disability	____	____	_____
Mental Impairment	____	____	_____
Psychological Impairment	____	____	_____
Other	____	____	_____

Mobility: Independent ambulation____ Crutches _____ Braces _____ Wheelchair _____ Walker _____

Special Precautions: _____

_____

_____

_____

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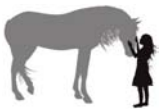

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Physician's Statement

Participant/Rider/Athlete Name: _____ Date of Birth: _____

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 a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Psychologist, etc) in the implementing of an effective equestrian program.

Physician Name: _____

Physician Signature: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Date: _____