COFFEE CREEK RIDING CENTER

"Therapeutic Horsemanship"
17 E. Coffee Creek Rd.. Edmond, OK 73034
(405) 340-8377

Participant Medical History & Physician Statement
(MUST BE COMPLETED BY PHYSICIAN)

Date_____

Dear Health Care Provider:
Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing the attached form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myosiitis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/
Tethered Cord/Hydromyelia

Other
Age - 2 1/2 to 11
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Participant_____ DOB_____ Height_____ Weight_____
Address_____
Diagnosis_____ Date of Onset_____
Past/Prospective Surgeries_____
Medications_____
Seizure Type_____ Controlled Y / N Date of Last Seizure_____
Shunt Present Y / N Date of Last Revision_____

Participant Medical History & Physician Statement
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Participant_____ Date_____

Special Precautions/Needs_____

_____

Mobility: Independent Ambulation Y / N Assisted Ambulation Y / N Wheelchair Y / N
Braces/Assistive Devices_____
For those with Down Syndrome: Date of AtlantoDens Interval X-rays _____ Result + / -
Neurologic Symptoms of AtlantoAxial Instability_____

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

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in Equine assisted activities. I understand that COFFEE CREEK RIDING CENTER will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to COFFEE CREEK RIDING CENTER for ongoing evaluation to determine eligibility for participation.

Name/Title_____ MD DO NP PA Other_____
Signature_____ Date_____
Address_____
Phone_____ License/UPIN Number_____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the phone number indicated below.

Sincerely,
Joy Milligan 405-340-8377