Hooves for the Heart, LLC
PO Box 5344
Eagle, CO 81631
970.524.8724
Fax 970.524.4114

Rider's Health Form

Please print clearly. All information is confidential.

Date _____

Dear Health Care Provider:

Your patient _____ DOB _____ Sex _____

(participant's name)

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

Orthopedic: Atlantoaxial Instability (include neurological symptoms), Coxa Arthrosis, Cranial Deficits, Heterotopic Ossification/ Myositis Ossification, Joint Subluxation/ Dislocation, Osteoporosis, Pathologic Fractures, Spinal Fusion/ Fixation, Spinal Instability/ Abnormalities.

Neurological: Hydrocephalus, Shunt, Seizure, Spina Bifida, Chiari II Malformation, Tethered Cord, Hydromyelia.

Medical/ Psychological: Allergies, Animal Abuse, Physical, Sexual or Emotional Abuse, Blood Pressure Control, Dangerous to Self or Others, Exacerbations of Medical Conditions, Fire Setting, Heart Conditions, Hemophilia, Medical Instability, Migraines, PVD, Respiratory Compromise, Recent Surgeries, Substance Abuse, Thought Control Disorders, Weight Control Disorder.

Other: Under 4 years old, Indwelling Catheters, Medications, Photosensitivity, Poor endurance, Skin Breakdown.

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact us. Happy Trails!

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Participant's Medical History and Physician's Statement

Please print clearly. All information is confidential.

Date _____

Client's Name _____ DOB _____ Height _____ Weight _____

Mailing address _____

_____

Phone _____

Diagnosis _____ Date of Onset _____

Past/Prospective Surgeries _____

_____

Medications _____

_____

Seizure Type _____ Controlled Y N Date of Last Seizure _____

Do you use any medical devices currently? _____

Special Precautions/ Needs _____

Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

(For Down Syndrome) AtlantoDens Interval X-ray Date _____ Result + -

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the riding program will weigh the medical information above against the existing

precautions and contraindications. I concur with a review of this person's abilities/ limitations in the implementation of an effective equine activity program.

Name _____ MD DO NP PA Other _____

Signature _____ Date _____

Address _____

_____

Phone _____ License/UPIN Number _____

Please comment on current or past special needs in the following areas:

Auditory	Visual	Tactile Sensation	Circulatory	Muscular
Speech	Cardiac	Integumentary/ Skin	Immunity	Balance
Pulmonary	Neurologic	Orthopedic	Learning Disabilities	Allergies
Cognitive	Emotional Balance	Psychological Stability	Other	