Attach to "Client Medical History & Physicians Statement" and give to Doctor.

JoyRide Center, Inc.
29550 Tudor Way
Magnolia, TX 77355
281-356-5900
Fax 281-356-5901
www.joyridecenter.org

Dear Health Care Provider:

Your patient, _
(Client's name)
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 this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instabilities – including neuralgic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Poor Endurance
Skin Breakdown
Medications – i.e. photosensitivity
Indwelling Catheters

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

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 the Horsemanship Program Manager at the center at the address/phone indicated below.

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Client Medical History And Physician's Statement

To be completed by physician and returned to JoyRide Center

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Client Name:_ M/F: _ Date of Birth: _

Guardian Name:_ Guardian Phone:_

Height: _ Weight: _ Has client had a bone density test: Y N Score:_

Diagnosis: _ Date of Onset: _

CurrentMedications: _

Known Allergies: Treatment:_

Past/Prospective Surgeries:_

Shunt Present: Y N Date of last revision: _

Seizure Type: _ Controlled: Y N Date of Last Seizure: _

Mobility: Independent Ambulation: ☐Yes ☐ No Assisted Ambulation: ☐Yes ☐No

Wheelchair: ☐Yes ☐ No Braces/Assistive Devices:_

For those with Down Syndrome: *A yearly medical exam including a complete neurologic exam has been done and shows no evidence of Atlantoaxial Instability.* ☐ Yes ☐ No _ Initials

For those with Scoliosis: Please indicate degree and location of curvature_

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

AREAS	YES	NO	AREAS	YES	NO	AREAS	YES	NO
Auditory			Skin			Orthopedic		
Visual			Immunity			Allergies/Asthma		
Tactile Sensation			Pulmonary			Learning Disability		
Speech			Neurologic			Cognitive		
Cardiac			Muscular			Psychological		
Circulatory			Balance			Pain		

Please provide additional comments for areas marked "yes" above or list any special precautions/needs:

____

____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Print Name/Title: ______________________________ MD DO NP PA Other __________ __

Signature: ______________________________ **Date:** ______________

Address: ____

Phone: (__________) ______________________ License/UPIN #: ______________________

Prescription for Physical or Occupational Therapy

JoyRide Center, Inc.
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www.joyridecenter.org

Client: ______________________________ **DOB:** ____________________

Prescription for evaluation and treatment by a Physical Therapist or Occupational Therapist at the JoyRide Center, Inc.

Recommended frequency: 1X per week

Precautions: Universal, _

____

Physician's Signature: _

Date: _

Please print or stamp:

Physician's name: _

Address: ____

____

Phone: ____