Please give entire medical form packet to client's Doctor.

ONCE COMPLETED PLEASE RETURN BY EMAIL TO OFFICEMANAGER@JOYRIDECENTER.ORG

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, _____ (clients 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. 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
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/others
Exacerbations of medical conditions (RA, MS)
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Recent Surgeries
Respiratory Compromise
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 Program Manager at our main line indicated at the top of this document.

Please note that clients with seizures are not immediately disqualified from mounted lessons. JoyRide Center just needs to be aware of how often and/or when they happen so that we can maintain our records and inform volunteers and staff what to do and expect during a seizure.

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: _____

Current Medications: _____

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: Y ___ N ___ Assisted Ambulation: Y ___ N ___ Wheelchair: Y ___ N ___

Braces/Assistive Devices: Y ___ N ___

Clients with Down Syndrome: *Has a yearly medical exam (including neurologic) been done that shows no evidence of Atlantoaxial Instability?* Y ___ N ___ Initials: _____

Clients with Scoliosis: Please indicate degree and location of curvature: _____

Please indicate current or past special needs in the following systems and 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 or 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 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.

Name/Title: _____ Signature: _____ Phone: _____

Address: _____

Date: _____ MD: ___ DO: ___ NP: ___ Other: ___ License/UPIN #: _____