

# 2026 Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N      Assisted Ambulation Y N      Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

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

Shunt Present: Y N      Date of last revision: \_\_\_\_\_

**For those with Down Syndrome:** AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + --

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

**Please indicate current or past difficulties 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			

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, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

**Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_