Oak Hill Farm
Therapeutic Riding

Health History / Physicians Release

Today's date:			
Student Name:		Date of birth:	
Address:			
Phone:			
Parent/Guardian Name:			
Address:			
Phone:			

Diagnosis:					Date of Onset:	
Medical History (include surgeries and dates):						
Medications:						
Allergies:						
Tetanus Shot:	No		Yes		Date of shot:	
Height:					Weight:	
					(over 185 lbs. must have prior authorization)	

By Brenda Malcolm Stoffel
PATH Certified Instructor

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Student Name:		Diagnosis:	

***** FOR PERSONS WITH DOWNS SYNDROME*****

Full Flexion and Extension X-rays for Atlantoaxial. Instability (AAI) is required within 5 years prior to entering Oak Hill Farm, Inc. Therapeutic Riding Program. Annual physical examination should reveal no symptoms of AAI. Follow-up X-rays should be every 10 years after. NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI.

Cervical X-ray for AAI Negative:		Date:		Doctor's initials:	

Please circle NO or YES for each of the following conditions. **Presence of a condition may or may not be appropriate to receive riding or driving instruction. Further information may be necessary.**

Spinal Fusion	No		Yes		Location and type:	
Spinal Instabilities / Abnormalities	No		Yes		Location and type:	
Spinal Orthoses	No		Yes		Location and type:	
Internal Spinal Stabilization Devices	No		Yes		Location and type:	
Scoliosis	No		Yes		Location and type:	
Kyphosis/Lordosis	No		Yes		Location and type:	
Hip subluxation/Dislocation	No		Yes		Describe:	
Osteoporosis	No		Yes		Location and type:	
Pathologic Fractures	No		Yes		Location and type:	
Coxas Arthrosis	No		Yes			
Arthritis	No		Yes		Location:	
Heterotopic Ossification	No		Yes			
Oseogenesis Imperfecta	No		Yes			
Cranial Deficits	No		Yes			
Hydrocephalus/Shunt	No		Yes		Location:	
Cerebral Palsy	No		Yes		Type:	

Student Name:		Diagnosis:	

Spinal Bifida	No		Yes		Location and degree:	
Tethered Cord	No		Yes		Degree:	
Chiari II Malformation	No		Yes		Degree:	
Hydromylia	No		Yes			
Spinal Cord Injury	No		Yes		Location and degree:	
Paralysis	No		Yes		Location and degree:	
Seizures	No		Yes		Type and date of last seizure:	
Controlled with Meds	No		Yes		Medication:	
Cancer	No		Yes		Location and type:	
Poor Endurance	No		Yes		Degree:	
Diabetes	No		Yes		Type:	
Peripheral Vascular Disease	No		Yes		Location and type:	
Varicose Veins	No		Yes		Location and type:	
Hemophilia	No		Yes			
Hypertension	No		Yes			
Serious Hearing Condition	No		Yes		Location and type:	
Stroke (CVA)	No		Yes		Location, type and results:	
Aneurysm	No		Yes		Location and results:	
Known Embolus	No		Yes			
Known Thrombus	No		Yes			
Indwelling Catheter	No		Yes			
Chronic Pain	No		Yes		Location and degree:	

Student Name:		Diagnosis:	

Internal Pumps	No		Yes		Location and type:	
G-tube	No		Yes		Location and type:	
Pacemaker	No		Yes		Location and type:	
Colostomy	No		Yes		Location:	
Other	No		Yes			

Surgeries	No		Yes		Please indicate location, type, and date below:

Auditory Difficulties		Vision	
Behavior Difficulties		Psycological	
Emotional Difficulties		Incontinence	
Postural Muscle Tone		Spasticity/ Rigidity	
Neuro-Sensation		Circulation	

Contractures	No		Yes		Braces	No		Yes	
Wheelchair	No		Yes		Cane/Crutches	No		Yes	
Walker	No		Yes						

General Health	
Additional pertinent information about this individual (pregnancy, etc.)	

Student Name:		Diagnosis:	

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. I understand that the riding center will evaluate the medical information that has been provided in relation to the existing precautions and contraindications. I concur with a review of this person's abilities/limitation by a Licensed/credentialed health professional (c.g. PT, OT, SLP, Psychologist, ect.) in the implementation of an effective equine activity program.

Name/Title: (please print)		MD/DO/NP/PA/Other	
Signature:			
Address:			
Phone:		Date: