Rider's Medical History and Physician's Statement
to *be completed annually*

Client's Name: _____Date of Birth: _____ Age:

Address: _____City/State: _____Zip:

Diagnosis: _____ Date of Onset:_____

*" For Persons with Down Syndrome:

☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date: _____

☐Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot: ☐ Yes ☐ No Date: Height: _____ Weight: _____

Seizure Type: _____ Controlled:_____Date of last seizure: _____

Medications:

_____□□□_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: ☐ Yes ☐ No Crutches: ☐ Yes ☐ No Braces: ☐ Yes ☐ No

Wheelchair: ☐ Yes ☐ No _____ Please indicate *any* special precautions:

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 disability/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print): _____

Physician's Signature:_____Date: _____

Address: _____Phone:_____

Dayspring Therapeutic Equestrian Center
2609 Fern Lake Cutoff
Marshall, TX 75672