Dear Health Care Provider,

Your patient is interested in participating in supervised equine activities with River Valley Riders, a Professional Association of Therapeutic Horsemanship International (PATH Intl.) member center.

In order to safely provide this service, we request that you complete the attached Medical History and Physician's Statement Form. 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 Instability (include neurologic symptoms)
Cranial Defects
Joint subluxation/dislocation
Osteoporosis
Spinal Joint Fusion/Fixation
Coxarthrosis
Heterotopic Ossification
Myositis Ossificans
Pathologic Fractures
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Spina Bifida
Tethered Cord
Seizure
Chiari II Malformation
Hydromyelia

Medical/Psychological

Allergies
Physical/Sexual/Emotional Abuse
Cardiac Condition
Exacerbations of Medical Conditions (e.g., RA, MS)
Hemophilia
Migraines
Respiratory Compromise
Substance Abuse
Weight Control Disorder
Animal Abuse
Blood Pressure Control
Dangerous to Self or Others
Fire Setting
Medical Instability
PVD
Recent Surgeries
Thought Control Disorders

Other

Indwelling Catheters/Medical Equipment
Medications (e.g., photosensitivity)
Skin Breakdown
Age - under 4 years
Poor Endurance

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact us at the address, phone number or email address indicated below.

Sincerely,
Cheryl Holt, Executive Director
River Valley Riders
8362 Tamarack Village
Suite 119-440
Woodbury, MN 55125
651-439-2558
info@rivervalleyriders.org

RIVER VALLEY RIDERS
EQUINE ASSISTED ACTIVITIES & THERAPIES

Enriching the lives of children and adults with special needs by providing equine assisted activities and therapies.

RIVER VALLEY RIDERS
Therapeutic Horse Riding and Driving Program
Participant's Medical History & Physician's Statement

Participant: _____ DOB:_____ Ht:_____ Wt:_____
Parent Name(s): _____
Address: _____
Phone: Home: _____ Cell: _____ Work: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: ☐ Yes ☐ No Date of Last Seizure: _____
Shunt Present: ☐ Yes ☐ No Date of Last Revision:_____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation: ☐ Yes ☐ No Assisted Ambulation: ☐ Yes ☐ No Wheelchair: ☐ Yes ☐ No
Braces/Assistive Devices: _____
For those with Down Syndrome: Neurologic Symptoms of Atlanto-Axial Instability: ☐ Present ☐ Absent

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensations			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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 River Valley Riders will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to River Valley Riders for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____