



SunDance Riding Therapy, Inc.
Rider's Medical History and Physician's Statement
(To be completed annually)

Client Name _____ Date of Birth _____

Address, City, State and Zip Code _____

Name of Parent/Guardian _____

Diagnosis _____

Date of onset _____

(For persons with Down Syndrome only)

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 _____

Mobility

Independent Ambulation Yes No

Crutches Yes No

Braces Yes No

Wheelchair Yes No

Please indicate any special precautions

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			

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 (i.e. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Physician Name _____

Physician Signature _____

Address _____

City, State & Zip Code _____

Phone Number _____ Date _____

Therapeutic and Safety Issues

Check and describe applicable issues (indicate current or history of):

- Inattention
- Hyperactivity
- Lack of concentration
- Learning disabilities
- Developmentally delayed
- Mentally challenged
- Boundary issues
- Social skills problems or problems with peers
- Anxiety, or Separation anxiety
- Phobias
- Aggressive or Assaultive
- Manipulative
- Unpredictable or dangerous behavior
- Sensory impairment
- Sensitivity, preferences
- Tics or stereotypic behavior
- Psychosomatic symptoms
- Medical issues
- Self-injurious behavior
- Suicidal ideations
- History of runaway
- Issues or parental support
- Issues of family support
- Sexual abuse/acting out
- History of physical
- Emotional abuse
- Hallucinations
- Delusions
- Illusions
- Dissociations
- Substance abuse problems
- Legal problems
- School problems
- History of animal abuse and/ or fire setting
- Seizure disorder
- Possible medication side effects

Signature _____

Date _____

Print Name _____