



HOPE Therapeutic Riding Center

P.O. Box 334, Langley, WA 98260 (360) 221-7656

Email: hope@whidbey.com

Website: www.hope-whidbey.org

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: _____ DOB _____ Height: _____ Weight: _____ lbs

Address: _____

Diagnosis: _____ Date of Onset: _____

Diagnosis: _____ Date of Onset: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Date of Last Physical: _____ Date of Last Tetanus shot: _____

Medications: _____

Seizure Type: _____ Controlled: Yes No

Date/Severity of Last Seizure: _____

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

Handedness: Left Right

Hearing Impaired: Yes No Hearing Aid: Yes No Which ear(s): Left Right Both

Uses Sign Language: Yes No Lip reads: Yes No Needs interpreter: Yes No

Severely Visually Impaired: Yes No If Yes, please provide details on Page 2.

For those with Down Syndrome:

AtlantoDens Interval X-rays, Date: _____ Results: + - _____

Neurologic Symptoms of AtlantoAxial Instability: _____

Participant: _____

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

SYSTEMS/AREAS	YES	NO	IF YES, PLEASE PROVIDE THOROUGH DETAILS
Allergies			
Behavioral			
Bone/Joint			
Breathing			
Circulation/Heart			
Cognitive/Thinking			
Communication/Speech			
Digestion/Elimination			
Emotional/Mental Health			
Hearing			
Motor skills (Fine/Gross)			
Muscular			
Neurological/Seizures			
Pain			
Prosthetics			
Sensation			
Vision			
Other:			

Participant: _____

NOTES:

To my knowledge, there is no reason why _____ cannot participate in supervised equine-assisted activities. However, I understand that the HOPE Therapeutic Riding Center will weigh the medical information above against the existing precautions and contraindications as per NARHA guidelines. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine-assisted activity program.

Name/Title: _____ **MD DO NP PA Other:** _____

Signature: _____ **Date:** _____

License/UPIN Number: _____

Name of Practice/Hospital: _____

City: _____ **State:** _____

Phone (Work): _____

“Grab the Reins of Life with HOPE!”