Participant's Medical History & Physician's Statement

Participant: _____DOB: _____Height: _____Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____Controlled: Y N Date of Last Seizure:_____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
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 Paradise Ranch will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Paradise Ranch for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA Other _____

Signature: _____Date: _____

Address: _____

Phone: (___) _____License/UPIN Number: _____