Renew Therapeutic Riding Center

4271 60th Street
Holland, MI 49423
Renewtrc.org

PARTICIPANT'S MEDICAL HISTORY/PHYSICIAN RELEASE

(Health Care Provider must complete and sign this form for each student)

Participant: _____ **Date**:_____
Address: _____
Primary Diagnosis:_____ICD Code: _____
Onset (please check one) [ ]Birth [ ]Childhood [ ]Adolescence [ ]Adult
Secondary_____ ICD Code_____ Tertiary_____ ICD Code_____
Date of Birth_____ Height_____ Weight_____Tetanus Shot [ ]no [ ]yesDate:_____

PLEASE LIST ALL CURRENT MEDICATIONS

1._____ taken for _____
2._____ taken for _____
3._____ taken for _____
Seizure type _____ Controlled? _____ Date of last seizure_____
Ambulatory: [ ]yes [ ]no Uses: [ ]Crutches [ ]Braces [ ]Cane [ ]Walker [ ]Wheelchair
Special precautions needed with this student: _____
_____
Please indicate current or past difficulties in the following systems/areas (including surgeries.)

System/Area	Yes	No	Comments
Allergies (incl. asthma)			
Auditory			
Balance			
Cardiac			
Circulatory (incl. hemophilia)			
Cognitive problems			
Emotional/psychological			
Immunity			
Integumentary/skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile sensation			
Visual (including glasses)			
Other			

The following may suggest precautions or contraindicate therapeutic horsemanship.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability-include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Cancer
Heterotopic Ossifications/Myositis Ossificans	Cardiac Condition
Internal Spinal Stabilization Device	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Pathological Fractures	Dangerous to Self or Others
Spinal Joint Fusion/Fixation	Exacerbations of medical conditions (e.g. MS, RA)
Spinal Joint Instability/Abnormalities	Fire settings
Neurologic	Hemophilia
Hydrocephalus/Shunt/Shunt revision	Medical Instability
Paralysis Due to Spinal Cord Injury	Migraines
Seizures	Peripheral Vascular Disease
Spinal Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia	Respiratory Compromise
Stroke	Recent Surgeries
Other	Substance Abuse
Age—under 4 years for therapeutic riding	Thought Control Disorders
Indwelling catheters/medical equipment	Weight Control Disorders
Medication side effects (e.g. photosensitivity)	
Poor endurance	
Skin breakdown	

Please indicate if any of the above conditions are present and to what degree.

_____

_____

_____

******FOR PERSONS WITH DOWN SYNDROME******

Neurological symptoms of Atlantoaxial Instability? [ ]Yes [ ]No

Date of neurological exam: _____

NEUROLOGIC EXAM RESULTS MUST BE UPDATED ANNUALLY AND FORM MUST BE SIGNED BY A LICENSED PHYSICIAN.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh this medical information against the existing precautions and contraindications. Therefore, I refer this person to the therapeutic riding center for ongoing evaluation to determine eligibility for participation.

Name (Please print):_____ Title: MD DO NP PA Other_____

Signature: _____ Date:_____

Address:_____

Phone:_____ License/UPIN Number:_____