UpReach Therapeutic Equestrian Center, Inc.
153 Paige Hill Road, Goffstown, NH 03045
603.497.2343 FAX: 603.497.5367

PARTICIPANT PHYSICIAN STATEMENT

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that 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
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control

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 the center at the address/phone indicated above.

Sincerely,

Lauren Kochakian

Lauren Kochakian, Assistant Program Director lauren@upreachtec.org

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Participant's Medical History and Physician's Statement

Participant: _____ DOB: ____/_____/_____ Height: _____ Weight: _____
Address: _____
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: AtlantoDens Interval X-rays, date: ____/_____/_____ Result: _____+ _____ --
Neurologic Symptoms of AtlantoAxial Instability: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
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. I understand that UpReach Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to UpReach Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ ___ MD ___DO ___NP ___PA ___Other

Signature: _____ Date: _____/_____/_____

Address: _____

Phone: _____ License/UPIN Number: _____ _____