STRIDE
P.O. Box 873032 | Wasilla, AK 99687
Message Phone: (907) 373-7716 | Email: info@stridealaska.org

RIDER MEDICAL HISTORY and PHYSICIAN'S EVALUATION

A qualified physician MUST complete this form to participate in the horseback riding program.

Rider's Name:_____- **DOB**:_____

Age:		Rider's Height:		Rider's Weight:		Male	Female
Diagnosis:						Date of Onset:	
Medications:							

Tetanus: Yes No Date of Last Tetanus:

Seizure Type: Controlled: Yes No Date of Last Seizure:

Shunt Present: Yes No Date of Last Revision:

If rider has Down Syndrome, Atlanto-Axial Subluxation? Yes No Cervical X-Ray for Subluxation? Positive Negative X-Ray Date: Neurological Symptoms of Atlanto-Axial Instability:_____ _____

Special Precautions/Needs:	

Mobility: Independent Ambulation Braces/Assistive Devices	Assisted Ambulation	Wheelchair

Please indicate current or past difficulties in any of the following area, by checking YES or No.

Concern	**YES**	**NO**	**If YES, please describe**
Allergies			_____
Auditory Impairment			_____
Speech Impairment			_____

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Visual Impairment	_____
Tactile Sensation	_____
Learning Disability	_____
Cognitive	_____
Cardiac	_____
Circulatory	_____
Integumentary/Skin	_____
Immunity	_____
Muscular	_____
Balance	_____
Neurological	_____
Orthopedic	_____
Postural Hypotension	_____
Pulmonary	_____
Emotional/Psychological	_____
Pain	_____
Other	_____

The following conditions may suggest precautions and contraindications to therapeutic horseback riding. Please note whether these conditions are present and to what degree.

Orthopedic Conditions	**YES**	**NO**	**If YES, please describe**
Atlanto-axial Instability			_____
Coxa Arthrosis			_____
Cranial Deficits			_____
Heterotopic Ossification/Myositis			_____
Joint Subluxation/dislocation			_____
Osteoporosis			_____
Pathological Fractures			_____
Scoliosis			_____
Spinal Fusion/Fixation			_____
Spinal Instability/Abnormalities			_____
Spondylolistesis			_____
Kyphosis/Lordosis			_____
Laminectomy/Fusion			_____

Neurological Conditions

Hyrocephalus/Shunt	_____
SpinaBifida/Chiari II Malformation/Tethered Cord/Hydromyelia	_____

Other

Asthma/COPD	_____
Indwelling Catheters	_____
Orthodontics	_____
Prosthetics	_____
Medications (i.e. photosensitivity)	_____
Sensory Loss	_____
Mental Impairment	_____
Skin Breakdown	_____
Poor Endurance	_____
Animal Abuse	_____
Physical/Sexual/Emotion Abuse	_____
Blood Pressure Control	_____
Dangerous to self or others	_____
Exacerbations of medical conditions	_____
Heart Conditions	_____
Hemophilia	_____
Medical Instability	_____
Migraines	_____

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PVD _____
Respiratory Compromise _____
Recent Surgeries _____
Substance Abuse _____
Thought Control Disorders _____
Weight Control Disorders _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that **STRIDE** 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 profession (e.g. PT, OT Speech Therapist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title (please print): _____ MD DO NO PA Other _____

Address: _____

City: _____

Phone: ( ) _____ License/UPIN Number: _____

Physician's Signature: _____ **Date:** _____

Please return this completed and *signed* form to:

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