Fair Hill Therapeutic Riding Center

Mailing Address: PO Box 396, Waymart, PA 18472
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Medical Form (Page 1 of 2)

Name ______________________________________Date of Birth ___/___/___ Sex: M/F

Parent/Guardian (if Applicable) ____

Address: ____

Height: ____________ Weight: ____________________

Diagnosis: ____

Secondary Diagnosis: ____

Date of Onset: ____

Comments: ____

____

____

Medications: (type, purpose, dose): ____

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Please indicate if the client has a history of the following problems. Please include **Complete** information, including surgical history pertaining to any items checked

Downs Syndrome		Autism	
Hydrocephalus/Shunt		Auditory Impairment	
Seizure, include type & date of last		Speech Impairment	
Allergies, (stimulus & reaction)		Visual Impairment	
Cardiac		Glasses/Contacts	
Circulatory		Learning Disability	
Gastrostomy		Mental Impairment	
Asthma/ COPD		Psychological	
Incontinence		Sensory loss	
Indwelling Catheter		Balance Impairment	
Contractures		Spinal Column Injury	

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Orthopedic History			
Subluxing or Dislocating Joints		Laminectomy	
Spinal Fusion		Scoliosis	
Kyphosis/Lordosis		Spondylolisthesis	
Osteoporosis		Heterotrophic Ossification	
Fractures:			
Location:		Healed	
Other			

Mobility Status____

Ambulatory? ____________________ Assistive Device___________________________

Precautions and Contraindications to therapeutic riding:

Seizure disorders
Hip subluxation? Dislocation Total hip arthroplasty
Osteogenesis Imperfecta
Scoliosis > 30
Atlantoaxial dislocation condition
Osteoporosis
Hydrocephalus/Shunt
Spinal Fusion Spinal instability
Spinal cord injury above T12

In my opinion the individual named above can participate in supervised mounted equestrian activities. I have reviewed the listed precautions and contraindications.

Physicians Signature

____Date: ________

Physician's Name (please print)____

Physician's Address: ____

Telephone Number: ____

Staff Signature _________________________Date received______ Date reviewed______
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