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: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assisted Devices: _____
FOR THOSE WITH DOWNS SYNDROME: Neurologic Symptoms if Atlanto Axial Instability: _____present _____ absent

PLEASE INDICATE CURRENT OR PAST SPECIAL NEEDS IN THE FOLLOWING SYSTEMS/AREAS, INCLUDING SURGERIES. THESES 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			
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 and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation ti determine eligibility for participation.

Name/Title_____ MD DO NP PA Other_____

Signature_____ Date: _____

Address:_____

Phone:_____ License/UPIN Number: _____