Courtney Grimshaw Equine Assisted Services Initiative

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Client: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of onset: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs:_____

Mobility: **Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N**

For Physician's Use Only:

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: _____ Result: + / -
Neurologic Symptoms of Atlanto-Axial Instability: _____

Physician's Statement
To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional in the implementation of an effective equestrian program.

Physician's Signature: _____Date: _____

Please print, type or stamp

Physician's Name: _____Phone: _____

Address: _____