**********MUST BE FILLED OUT, SIGNED AND DATED BY PHYSICIAN**********

Little Britches Therapeutic Riding

Medical History/Physician Release

Name_____ Date of Birth_____
Address _____
Name of Parent/Guardian_____ Date of Onset_____
Diagnosos_____

**FOR PERSONS WITH DOWN SYNDROME:
Cervical X-ray for Atlantoaxial instability: Positive_____ Negative_____ X-ray date_____

Tetnus Shot: Yes_____ No_____ Date_____ Height_____ Weight_____

Seizure Type_____ Controlled_____ Date of last seizure _____

Medications_____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes____ No___ Crutches Yes_____ No_____ Wheelchair Yes_____ No_____

Please indicate any special precautions _____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician Name (please print) _____

Physician Signature: _____

Address: _____ City _____ State _____ Zip _____

Phone: (_____) _____ Date _____