Physician's Statement

Hooves of Hope Equestrian Center, Inc.
735 Chenault Bridge Rd. Lancaster, KY 40444
(859) 792-8938

Dear Physician:

Your patient,____(participant's name) is interested in participating in supervised equestrian activities at Hooves of Hope Equestrian Center, Inc.

In order to safely provide this service, our center requests that you complete/update the attached **Medical History and Physician Statement Form**. Please note that the following conditions may suggest precautions and contraindications to Equine Assisted Services. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Participant:____DOB:___________________________

Height:____Weight:____________________________________

Diagnosis:____

Date of Onset: ____

Past/Prospective Surgeries: ____

Date of last seizure:______________________________Seizure Type: ____________________________

Controlled? Yes No: ____

Please List If Applicable

Medications:____

Medical Devices: ____

Allergies: ____

Does this participant have:

		Description
Asthma	**Yes or No**	
EpiPen	**Yes or No**	
Inhaler	**Yes or No**	

Does this participant use:

		Description
Walker	**Yes or No**	
Crutches	**Yes or No**	
Wheelchair	**Yes or No**	
Any Type of Body Brace such as leg brace	**Yes or No**	

Medical History and Physician Statement Form

Orthopedic: Please mark anything present in the patient

Condition	Yes	No	Description
Spinal Fusion			
Atlantoaxial Instability			
Kyphosis			
Osteoporosis			
Coxas Arthrosis			
Cranial Deficits			
Spinal Instability Abnormalities			
Scoliosis			
Lordosis			
Pathological fraction			
Osteogenesis Imperfecta			
Spinal Orthoses			
Internal Spinal Stabilization Device			
Other			

Neurological: Please mark anything present in the patient

Condition	Yes	No	Description
Hydrocephalus/shunt			
Spina Bifida			
Chiari II Malformation			
Tethered Cord			
Paralysis due to Spinal Cord Injury			
Hydromyelia			
Seizure Disorder			
Other			

Medical/Surgical: Please mark anything present in the patient

Condition	Yes	No	Description
Allergies			
Poor Endurance			
Diabetes			
Hip/Joint Subluxation and Dislocation			
Hemophilia			
Heart Condition			
Recent Surgery			
Cancer			
Peripheral Vascular Disease			
Hypertension			
Stroke			
Heterotopic Ossificication			
Other			

Other Concerns: Please mark anything present in the patient

Diagnosis	Yes	No	Description
Behavioral			
Weight control disorder			
Cognitive concerns			
Memory concern			
Indwelling catheter			
Acute exacerbation of chronic disorder			
Other			

ONLY for Individuals with Down Syndrome:
Neurologic symptoms of Atlanto Axial Instability: Present ________ Not Present ________

Name/Title:______________________________MD DO Other: _________________________

Signature:________________________________ Date:__________________________________

Address:_________________________________ Phone: ________________________________

License/UPIN Number:____

Physician's Release

To my knowledge, there are no apparent clinical concerns prohibiting this person from participating in supervised Equine Assisted Services including sitting astride a horse in movement. I understand that Hooves of Hope will weigh the medical information above against the existing precautions and contraindications to determine eligibility for participation.

Signature:____Date:______________________________

Physician's Printed Name: ____

Address/City/Zip: ____