HIGH & MIGHTY™
THERAPEUTIC RIDING AND DRIVING CENTER INC.
501 (c)(3)

Date:_____

Dear Health Care Provider:

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

Orthopedic

Atlantoaxial Instability- include neurologic symptoms
Coxarthritis
Cranial deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/
Tethered cord/Hydromyelia

Other

Age-under 4 years
Indwelling Catheters/Medical Equipment
Medications- e.g., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact High & Mighty Therapeutic Riding and Driving Center, Inc. at 518-672-4202 / info@high-n-mighty.org

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:_____
Shunt Present: Y___ N___ Date of last revision:_____
Special Precautions/Needs_____
_____
Mobility: Independent Ambulation Y___ N___ Assisted Ambulation Y___ N___ Wheelchair Y___ N___
Braces/Assistive Devices:_____
For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present___ Absent___

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

	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			

In my opinion, this person is not medically precluded from participating in supervised equine services. I understand that High & Mighty Therapeutic Riding and Driving Inc. will compare the above diagnosis and medical information to the current precautions and contraindications.

Name/Title:_____ MD DO NP PA Other:_____
Signature:_____ Date:_____
Address:_____
Phone:_____ License UPIN Number_____