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
- Coxarthrosis
- Cranial deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

**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

**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

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](mailto: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:

<table>
<thead>
<tr>
<th>System/Area</th>
<th>Y</th>
<th>N</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tactile Sensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary/Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________

71 County Route 21C ● Ghent, NY 12075 ● 518-672-4202 ● high-n-mighty.org