FREE REIN
CENTER FOR THERAPEUTIC RIDING AND EDUCATION
PO Box 1325
Brevard, NC 28712
828-883-3375

Rider's Medical History and Physician's Statement
To be completed by Licensed PHYSICIAN

Name:_____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell:_____

Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

In order to safely provide this service, Free Rein requests that you complete/update this Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing both sides of this form, please note whether these conditions are present, and to what degree. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact Free Rein.

Current Medications: _____

** For Person with Down Syndrome	YES	NO	DATE
**Negative Cervical X-Ray for Atlantoaxial Instability			
** Negative for Clinical Symptoms of Atlantoxial Instability			

	YES	NO	Controlled	Date of Last Seizure
SEIZURES				

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

	YES	NO	COMMENTS
Medications, i.e. photosensitivity			
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Peripheral Vascular Disease			
Varicose Veins			
Hemophilia			
Hypertension			
Serious Heart Condition			
Stroke			

(over)

	YES	NO	COMMENTS
Neurological			
Hydrocephalus/Shunt			Date of Last Revision
Spina Bifida			
Tethered Cord			
Chiari II Malformation			
Hydromyelia			
Paralysis Due to Spinal Cord Injury			
	YES	NO	COMMENTS
Orthopedic			
Spinal Fusion			
Spinal Instabilities			
Spinal Abnormalities			
Scoliosis			
Kyphosis			
Lordosis			
Hip Subluxation			
Hip Dislocation			
Osteoporosis			
Pathological Fractures			
Coxas Arthrosis			
Myositis/Heterotopic Ossification			
Osteogenesis Imperfecta			
Cranial Defects			
Spinal Orthosis			
Internal Spinal Stabilization Devices			
	YES	NO	COMMENTS
Learning Disability			
Mental			
Psychological			
Allergies			
Cancer			
Poor Endurance			
Recent Surgery			
Diabetes			
Indwelling Catheter			
Independent Ambulation			
Crutches/Wheelchair			
Skin Breakdown			
Blood Pressure Control			
Pulmonary			
Muscular			
Other			

To my knowledge there is no reason why this person can not 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 a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, PT, Speech, LPC, etc.) in the implementation of an effective equestrian program.

Physician's Name (please print) _____

Physician's Signature _____

Address _____ City _____

State _____ Zip Code _____ Phone _____ Date _____