Freedom Ride, Inc.
1905 Lee Road
Orlando, FL 32810
Voice: (407) 293-0411 Fax: (407) 293-6280
www.freedomride.com

Rider's Medical History and Physician's Release –Must be completed by Physician

Name: ________________________________DOB:________Height:________Weight__________

Address: ____

Name of [ ]Parent or [ ] Guardian:____

Primary Diagnosis: ____________________________________ Date of Onset: ________________

Secondary Diagnosis __________________________________ Date of Onset: ________________

Tertiary Diagnosis ____________________________________ Date of Onset ________________

Shunt Present: Y N Date of Last Revision:___________Tetanus shot: Y/N: Date if Yes _________

Seizure Type: ________________________ Controlled: Y N Date of last seizure: _____________

PLEASE LIST ALL CURRENT MEDICATIONS:

1. ____ taken for ________________________
2. ____ taken for ________________________
3. ____ taken for ________________________

Any contagious diseases: ____

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility: Independent Ambulation: Yes _____ No _____ Crutches: Yes _____ No _____
Wheelchair: Yes _____ No _____ Braces: Yes _____No _____

Past/Prospective Surgeries: ____

Special Precautions/Needs: ____

Physician's signature required on other side

2007

Physician Information

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		**Medical/ Surgical**	
Spinal Fusion		Allergies	
Spinal Instabilities/ Abnormalities		Cancer	
Internal Spinal Stabilization Devices		Poor Endurance	
Atlantoaxial Instabilities		Recent Surgery	
Scoliosis		Diabetes	
Kyphosis		Peripheral Vascular Disease	
Lordosis		Varicose Veins	
Hip Subluxation and Dislocation		Hemophilia	
Osteoporosis		Hypertension	
Pathologic Fractures		Serious Heart Condition	
Coxas Arthrosis		Stroke (Cerebrovascular Accident)	
Heterotopic Ossifaction			
Osteogenesis Imperfecta			
Cranial Deficits			
Spinal Orthoses		**Neurologic**	
		Seizure disorders	
Secondary Concerns		Hydrocephalus/shunt	
Behavior problems		Spina Bifida	
Age two - four years		Tethered Cord	
Acute exacerbation of chronic disorder		Chiari II Malformation	
Indwelling catheter		Hydromyelia	
Integumentary/Skin		Paralysis due to Spinal Cord Injury	

Riders with Down Syndrome- PLEASE NOTE:

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

a) Most recent cervical x-ray for AAI: [ ]Positive [ ]Negative ………. Date of X-Ray ______________________

b) Annual cervical exam for AAI [ ]Positive [ ]Negative ………..Date of Exam___________________________

Physician Verification – Please PRINT your name, sign & date – THANK YOU

To my knowledge, there is no reason why this person cannot 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.

Physician Name/Title: (please print) ____

Signature: ____Date:________________Phone:_________________

Address: ____ ______ ____________________

Additional Comments:____

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