Freedom Ride Inc

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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			

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 (page 2)

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

PARTICIPANTS WITH DOWN SYNDROME – PLEASE NOTE & COMPLETE			
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 an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with Atlantoaxial Instability.			
Annual neurological exam for Atlantoaxial Instability:	☐ 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 final decision regarding acceptance rests with the Freedom Ride, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses.		
Physician Name/Title (Please Print):		
Signature:	Date:	Phone:
Address:		
Additional Comments:		