MANE & TAILL Therapeutic Horsemanship Academy
Participant's Medical History/Physician's Statement

Name _____ DOB_____ Height _____ Weight _____

Address _____

Diagnosis _____

Past/Prospective Surgeries _____

Medications _____

Seizure Type _____ Controlled Yes ___ No ___ Date of Last Seizure _____

Shunt Present Yes __ No ___ Date of last revision _____

Ambulation: Independent _____, Assisted _____, Wheelchair _____

Braces/Assistive Devices: _____

If Down Syndrome: AtlantoDens Interval X rays, Date _____ Results: + - _____

Neurological Symptoms of AtlantoAxial Instability: _____

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

	Yes	No	Comment
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integument/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA center will weight medical information above against existing precautions, and contraindications. I concur with a review of this person's abilities/limitations b a licenses/credentialed health professional (e. g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name _____ MD DO NP PA Other ____

Signature _____ Date _____

Phone ( ) _____ License/UPIN Number _____