*************MUST BE FILLED OUT, SIGNED AND DATED BY PHYSICIAN*************

Little Britches Therapeutic Riding

Medical History/Physician Release

Name____ Date of Birth__________________
Address ____
Name of Parent/Guardian____ Date of Onset________________
Diagnosis ____

**FOR PERSONS WITH DOWN SYNDROME:
Cervical X-ray for Atlantoaxial instability: Positive__________ Negative___________ X-ray date___________

Tetnus Shot: Yes______ No_______ Date_______ Height____________ Weight_____________

Seizure Type_____________________________________ Controlled____________ Date of last seizure __________

Medications____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using back of form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes____ No___ Crutches Yes_____ No_____ Wheelchair Yes_____ No_____

Please indicate any special precautions ____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Physician Name (please print) ____

Physician Signature: ____

Address: ____________________________ City ___________________ State ____________________ Zip __________

Phone: (________) ____ Date _________________________________