Horses Unlimited, Inc.
PO Box 30194 Cromberg, CA 96103
therapy@horsesui.org
530-280-1565
horsesUI.org
A charitable organization providing therapeutic horseback riding for people with disabilities

Date:
Dear Healthcare Provider:
Your patient_____
(participant's name)
is interested in participating in supervised equine assisted activities at Horses Unlimited, Inc. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation
Osteoporosis
Pathogenic Fractures
Coxes Arthritis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurological

Hydrocephalus/ Shunt
Spina Bifida
Tethered Cord
Chiral II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorder

Medical/ Surgical

Allergies
Cancer
Poor endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Conditions
Stroke / Cerebrovascular Accident

Secondary Concerns

Behavior Problems
Age under two years
Age two to four years
Acute exacerbation of chronic disorder
Indwelling Catheter

Thank you very much for your assistance!

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Rider's Medical History and Physician's Statement

to be completed annually

Name_____ Date of Birth_____
Address _____ City _____ State _____ Zip _____
Name of Parent/Guardian _____
Diagnosis_____Date of Onset_____
**For persons with Down Syndrome:
▢ Negative Cervical X-ray for Atlantoaxial Instability X-ray date_____
▢ Negative for clinical symptoms of Atlantoaxial Instability
Tetanus shot ▢ No ▢ Yes Date of shot_____ Height_____ Weight_____
Seizure Type (if any)_____, Controlled ▢ Yes ▢ No, Date of last seizure_____
Medications_____

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

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Other			

Mobility: Independent ambulation ▢ Yes ▢ No, Crutches ▢ Yes ▢ No, Braces ▢ Yes ▢ No
Wheelchair ▢ Yes ▢ No Please indicate any special precautions_____
_____

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 and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print)_____Phone_____
Address _____ City _____ State _____ Zip _____
Physician Signature_____