



HorseSense
Riding Therapy Program
A Camillus Foundation Project

Rider's Medical History

To be completed annually

Name: _____ Date of Birth _____

Address: _____

Name of Parent or Guardian _____

Diagnosis: _____ Date of on set: _____

I* _____ ** For persons with Down Syndrome: _____ I
I Cervical X-Ray for Atlantoaxial Instabilities: Positive ___ Negative ___ Date _____ I
I _____ I

If Seizures What Type _____ Controlled _____ Date of last seizure _____

Medications _____

Tetnus Shot /_/ Yes /_/ No Date _____

Height ___ Weight ___

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.

Areas	Yes	No	Comment
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

Braces /_/ Yes /_/ No Wheelchair /_/ Yes /_/ No

Please indicate any special precautions _____