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PHYSICIAN STATEMENT
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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 precautions 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) _____
Physician Signature _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date _____
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Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. 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 and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Anthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

Hydorcephalus/shunt
Spina Bifida
Tethered Cord
Hydromyelia
Paralysis due to Spinal Cord Injury

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior Problems
Age under two years
Age two - four years
Acute Exacerbation of chronic disorder

Chiari II Malformation
Seizure Disorder