Information for Physician

(Please give to the participant's physician as a guideline for Therapeutic Riding)

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding**. Please complete the TROT Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.**

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical

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

Neurological

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns

Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of
Chronic Disorder

Physician Assessment Form

(To be filled out by the participant's physician)

Participant Name_____ DOB_____ Height_____ Weight _____

Diagnosis: _____ Date of Onset_____

Past/Prospective Surgeries _____

Medications _____

Seizures: Y N Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunts/Implants/ _____

Hospitalizations/Surgery _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Neurologic Symptoms of Atlanto Axial Instability: Yes_____ No _____

Please indicate and comment on any Special Problem Areas Below:

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

Physician Release

Participant name: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that TROT will weigh the medical information contained in the physician release form against 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, Therapist, Psychologist, etc.) In the implementing of an effective equestrian program.

Physician's Signature:_____ Date: _____

Physician's name, address, and telephone number: (please print, type or stamp):

_____

_____

_____

***For All Participants with <u>Down syndrome</u>:** Physician *Annual* Medical Clearance report for Neurologic Symptoms of Atlanto Axial Instability Exam

_____ has undergone a neurological exam by a licensed physician to test for symptoms consistent with atlantoaxial instability.

_____ has been given medical clearance by the licensed physical below, due to the results of the neurological exam that denies any symptoms consistent with atlantoaxial instability.

Physician name _____

Signature: _____

Stamp: