



Information for Physician

*(Please give to the participant's physician as a guideline for **Unmounted** ground based equine assisted activities in a therapeutic environment)*

The following conditions, if present, may represent precautions or contraindications to safely interacting with horses. **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
Coxarthrosis
Heterotopic Ossification
Spinal Orthoses
Cranial Deficits
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)
Skin Breakdown
Cardiac Condition
Medical Instability
Pathologic Fractures Exacerbations of -
Medical Conditions (e.g., RA, MS)

Neurological

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

Other

Acute exacerbation of chronic disorder
Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Medical Equipment
Medications - e.g., Photosensitivity
Weight Control Disorder
Thought Control Disorders

Psychological

Animal Abuse
Physical/Sexual/Emotional Abuse
Fixation Fire Setting
Dangerous to Self or Others
Substance Abuse



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, **unmounted**, ground-based, equine assisted activities supervised by certified facilitator or specialist. 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 implementation of an effective ground based equestrian program.

Physician's Signature: _____ Date: _____

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

If this person is **not cleared for unmounted ground based equine assisted activities**, please explain why:

***For All Participants with Down syndrome:** 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:
