C-Bar Horsemanship

Enhancing lives one step at a time. PATH Member Center

MEDICAL EVALUATION / PHYSICIAN RELEASE

This form must be completed and signed by a health care professional and updated annually:
The following conditions, if present, may represent **precautions or contraindications** to therapeutic horseback riding. Therefore, please note if any of these conditions are present, and to what degree. **Please be as specific as possible so that we may best serve the participant's needs.** (Circle conditions that are present and add specifics below.)

Participant:_____ **Birthdate:**_____**Height**_____ **Weight**_____

Primary Diagnosis:_____

Orthopedic	**Medical**	**Neurologic**
Spinal Fusion	Allergies	Hydrocephalus/shut
Spinal Instabilities/Abnormalities	Cancer	Tethered Cord
Atlantoaxial instabilities	Poor endurance	Chiari ll Malformation
Scoliosis (>30, riding is contraindicated)	Recent surgery	Hydromyelia
Kyphosis	Diabetes	Paralysis due to spinal cord injury
Lordosis	Peripheral Vascular Disease	Seizure Disorders
Hip Subluxation and Dislocation	Varicose Veins	
Osteoporosis	Hemophilia	

Secondary Concerns		
Pathologic Fractures	Hypertension	Behavior Problems
Coxas Arthrosis	Serious Heart Condition	Age under two years
Heterotopic Ossification	Stroke (Cerebrovascular Accident	Age two – four years
Osteogenesis Imperfecta		Acute exacerbation of chronic disorder
Cranial Deficits		Indwelling catheter
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Other Condition(s) not listed above: _____

Please indicate specifics related to any existing health conditions, including degree of conditions such as scoliosis and osteoporosis, type of behavior problems, recent surgeries, type of seizures etc:

_____

_____

For participants with Down Syndrome

Please note:
Due to the nature of equine activities, including horseback riding, individuals diagnosed with Downs Syndrome can not be accepted for participation without proof of a negative diagnostic x-ray for Atlantoaxial Instability.
Please provide the following information:

a) Most recent cervical x-ray for AAl: [ ]Negative …..Date of x-ray _____
b) Annual cervical exam for AAl: [ ]Negative … Date of Exam _____
c) Neurologic Symptoms of AAI: [ ] Present · [ ] Absent …Date of Exam _____

Does the participant have a health concern and/or surgeries in any of the following areas? If yes, please explain:

Auditory_____

Visual _____

Speech _____

Cardiac _____

Circulatory _____

Pulmonary _____

Neurological _____

Muscular _____

Orthopedic _____

Allergies _____

Learning Disabilities _____

Mental or Psychological Impairment _____

Other: _____

Please describe any concerns or special medical or physical precautions or adaptations needed:

_____

HEALTH CARE PROVIDER'S STATEMENT
(Signature Required)

To the best of my knowledge, there is no reason why this person cannot participate in supervised equestrian activities, including therapeutic horseback riding. However, I understand that the staff at C-Bar Horsemanship (a Member Center of the Professional Association of Therapeutic Horsemanship, Int'l) will consider the medical information I have provided to determine their ability to meet the individual's existing health conditions, precautions and requirements.

Health Care Provider_____**Title**_____

Office Address: _____**Phone:** _____

REQUIRED:

Health Care Provider Signature _____ **Date:** _____