Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____
Weight: _____

Address:
_____
_____

Diagnosis: _____ Date of Onset:
_____

Past/Prospective Surgeries:
_____

Medications:
_____
_____

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

Shunt Present: Y N Date of last revision:
_____

Special Precautions/Needs:
_____

_____
_____

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

Braces/Assistive Devices:
_____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			

Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____