Charleston Area Therapeutic Riding, Inc.
P.O. Box 146 • Johns Island, SC 29457-0146 • (843) 559-6040 • Fax (843) 559-0176

P4

STUDENT MEDICAL HISTORY

Name: ___________________________________ Date of Birth: ____________________________

Address: ____

Name of Parent or Guardian: ____

Diagnosis: __________________________________ Date of Onset: _____________________________

*** For persons with Down Syndrome***

- ◻ Negative Cervical X-ray for Atlantoaxial Instability X-ray Date: _________________________
- ◻ Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: ◻ Yes ◻ No Date: ____/____/____ Height: ____ '_____" Weight: __________lbs.

Seizure Type___________________ Controlled _______________ Date of last seizure _____/_____/____

Medications ____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment. ____

Areas	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: **Independent Ambulation** ◻ Yes ◻ No **Crutches** ◻ Yes ◻ No **Braces** ◻ Yes ◻ No

Wheelchair ◻ Yes ◻ No **Please indicate any special precautions:** ____________________

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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: ( ) ______________________ Fax: ( )__________________ Date: ______________

Please see other side →

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 Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
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)

Neurologic

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
Acute exacerbation of chronic disorder
Indwelling catheter