

**Hoofbeats Therapeutic Riding Center, Inc.**

At the Virginia Horse Center  
 P.O. Box 979, Lexington, VA 24450  
 Ph: 540 464-3337 e-mail: hoofbeats@rockbridge.net  
 Website: [www.hoof-beats.com](http://www.hoof-beats.com)

North American Riding for the Handicapped Association, Inc.  
 A Premier Accredited Member Operating Center

**PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT  
 (To be completed annually by Primary Physician)**

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name of Parent/Guardian/Adult Caregiver, if any: \_\_\_\_\_

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, Date: \_\_\_\_\_  No

Seizure Type \_\_\_\_\_ Controlled \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Medications: \_\_\_\_\_

Precautions for outdoor activities? (Allergies, sun/heat sensitivity, asthma, etc.) \_\_\_\_\_

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 Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation  Yes  No; Crutches  Yes  No; Braces  Yes  No Wheelchair  Yes  No

Please indicate any special precautions \_\_\_\_\_

Continued next page

Participant's  
Name: \_\_\_\_\_

### PHYSICIAN'S STATEMENT

To my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. However, I understand that Hoofbeats Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications. I concur that a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) may be helpful in the implementing of an effective equestrian program.

Physician Name (Please Print) \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_

### 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

Varicose Veins  
Hemophilia  
Hypertension  
Serious Heart Condition  
Stroke (Cerebrovascular Accident)

#### Secondary Concerns

Behavior Problems  
Age under 2 years  
Age 2-4 years  
Acute exacerbation of chronic disorder  
Indwelling catheter

#### Neurologic

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

**Please complete forms and send to:**  
**Hoofbeats Therapeutic Riding**  
**Center, Inc.**  
P.O. Box 979  
Lexington, VA 24450

#### Medical/Surgical

Allergies  
Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease