Date filled out: _____

MEDICAL HISTORY

Student Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Special Precautions/Needs: _____

Mobility (please check one): [ ] Independent Ambulation [ ] Assisted Ambulation [ ] Wheelchair

Braces/Assistive Devices: _____

Does the student have any of the following as a part of their diagnosis? Please answer Y or N:

Seizures Y N If Yes, seizure type: _____ Controlled: Y N Date of last seizure: _____

Shunt Y N Date of last revision: _____

Down Syndrome Y N If your child has been diagnosed with Down syndrome, please contact your instructor to discuss potential issues with Atlantoaxial Instability to make sure that riding is not contraindicated. Additional forms may be required for your child to participate in our equine related programs.

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y/N	Comments
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional/Mental Health		
Behavioral		
Pain		
Bone/Joint		
Muscular		
Thinking/Cognitive		
Balance		
Allergies		
Other		