Date filled out: _____

PHYSICIANS APPROVAL TO PARTICIPATE

Dear Health Care Provider:

Your patient, _____, would like to participate in an equine activities program at Horse n' Buddy. In order to safely provide this service, our center requests that you complete the Physician's Approval to Participate and attach a current standard medical and vaccine record.

Diagnosis: _____ Date of Onset: _____

Special Precautions/Needs: _____

_____

*** please note that the following conditions may suggest precautions and contraindications to participations in equine activities. Therefore, when completing this form, please ntoe whether these conditions are present, and to what degree.*

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification
Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e., Photosensitivity
Poor Endurance
Skin Breakdown

Neurologic
Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/ Chiari II Malformation/Tethered Cord/Hydromyelia

Given the above diagnosis and my knowledge of this patient, this person is not medically precluded from participation in supervised equine activities and/or therapies. I understand that the PATH Intl. Member Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Member Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____