Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. **Please complete the Healing Horses Kauai Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.**

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

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

Medical/Surgical
Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns
Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of Chronic Disorder

(Please give to the rider's physician as a guideline to Therapeutic Riding)

Rider Health History / Physician Assessment

Rider Name _____ DOB __ / __ / ____ Height _____" Weight _____

Address _____

Diagnosis:_____ Date of Onset _____

Past / Prospective Surgeries: _____

Medications:_____

Seizures: Y / N If yes, type: _____ Controlled: Y / N Date of Last Seizure _____

Shunts/Implants/Appliances: _____

Hospitalizations/Surgery: _____

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

Neurological Symptoms of Atlanto Axial Instability _____

Please indicate and comment on any Special Problem Areas below:

Area	**Yes**	**No**	**Comment**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensory			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Other			

Students with Down Syndrome must have the following

Atlanto-Axial Neurological Exam: Date_____ Result: _____

Physician Release

Rider Name: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Healing Horses Kauai will weigh the medical information contained in the physician release form against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, Therapist, etc.) in the implementing of an effective equestrian program.

Physician's Signature: _____ Date: ___ / ___ / _____

Physician's name, address and telephone number (please print or stamp)

(To be filled out, dated, adn signed by the rider's physician and returned to Healing Horses Kauai prior to any participation in the program)