**Horse SenseAbility**
Wildstar Farm
16 Nason Hill Lane, Sherborn MA 01770
P: 508-744-6774 | F: 877-205-1961 |info@HorseSenseAbility.org

## PARTICIPANT PHYSICIAN STATEMENT

Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

**Neurologic**
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/ Hydromyelia

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

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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact me.

Sincerely,

Polly Kornblith, Ed.M, TRI, ESMHL
pk@horsesenseability.org

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**PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT**

Participant: _____ DOB: ____/_____/_____

Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Date of Onset: _____/_____/_____

Past/Prospective Surgeries: _____

Medications: _____

_____

Seizure Type: _____ Controlled: ___ YES ___ N0

Date of Last Seizure: _____/_____/_____

Shunt Present: ___ YES ___ N0 Date of last revision: ____/_____/_____

Special Precautions/Needs: _____

_____

Independent Ambulation: ___ YES ___ N0 Assisted Ambulation: ___ YES ___ N0

Wheelchair: ___ YES ___ N0 Braces/Assistive Devices: _____

For those with Down Syndrome:

AtlantoDens Interval X-rays, date: ____/_____/_____ Result: _____+ _____ --

Neurologic Symptoms of AtlantoAxial Instability:

_____

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

| **SPECIAL NEEDS** | **YES** | **NO** | **COMMENTS** |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Tactile sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning disability | | | |
| Cognitive | | | |
| Emotional/psychological | | | |
| Pain | | | |
| Other | | | |

*Check and describe all current therapeutic and safety issues:*

- ❑ Inattention _____
- ❑ Hyperactivity _____
- ❑ Lack of concentration _____
- ❑ Learning disabilities _____
- ❑ Developmentally delayed _____
- ❑ Cognitively challenged _____
- ❑ Boundary issues _____
- ❑ Social skills problems _____
- ❑ Problems with peers _____
- ❑ Separation anxiety _____
- ❑ Anxiety _____
- ❑ Phobias _____
- ❑ Aggressive _____
- ❑ Assaultive _____
- ❑ Manipulative _____
- ❑ Unpredictable or dangerous behavior _____
- ❑ Sensory impairment _____
- ❑ Sensitivity/preferences _____
- ❑ Tics or stereotypic behavior _____
- ❑ Psychosomatic symptoms _____
- ❑ Medical issues _____
- ❑ Self-injurious behavior _____
- ❑ Suicidal ideations _____
- ❑ Runaway _____

- ❑ Issues of parental or family support _____
- ❑ Sexual abuse/acting out _____
- ❑ Physical abuse _____
- ❑ Emotional abuse _____
- ❑ Hallucinations _____
- ❑ Delusions _____
- ❑ Illusions _____
- ❑ Dissociations _____
- ❑ Substance abuse problems _____
- ❑ Legal problems _____
- ❑ School problems _____
- ❑ Animal abuse _____
- ❑ Fire setting _____
- ❑ Seizure disorder _____
- ❑ Medication side effects _____

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities. I understand that Horse SenseAbility will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Horse SenseAbility for ongoing evaluation to determine eligibility for participation.

Signature: _____ Date: _____/_____/_____

Name: _____

Title: _____ License/UPIN Number: _____

Address: _____

Phone: _____