PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

To be completed by Physician

Participant: DOB Height: Weight

Address

Diagnosis: Date of Onset:

Past/Prospective Surgeries:

Medications:

Seizure Type Controlled: Y☐ N☐ Date of Last Seizure:

Shunt Present: Y☐ N☐ Date of last revision

Special Precautions/Needs

Mobility: Independent Ambulation Y☐ N☐ Assisted Ambulation Y☐ N☐ Wheelchair Y☐ N☐

Braces/Assistive Devices:

For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present☐ Absent☐

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory	☐	☐	
Visual	☐	☐	
Tactile Sensation	☐	☐	
Speech	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Integumentary/Skin	☐	☐	
Immunity	☐	☐	
Pulmonary	☐	☐	
Neurologic	☐	☐	
Muscular	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning Disability	☐	☐	
Cognitive	☐	☐	
Emotional/Psychological	☐	☐	
Pain	☐	☐	
Other	☐	☐	

See next page for Signature

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

Name/Title _____ MD☐ DO☐ NP ☐ PA☐ Other _____

Signature _____ Date _____

Address: _____ Phone: _____ License/UPIN Number _____