WISH UPON A HORSE
THERAPEUTIC RIDING CENTER
190 Greenwood Drive, Hilton Head Island, SC 29928
843.671.2586 tel • 843.671.2582 fax
www.wishuponahorsehhi.org

Participant's Medical History and Physician's Statement

Participant: _____

Name / Address of Guardian: _____ Tetanus Shot: YES NO
Date:

DOB: _____ Age: _____ Height: _____ Weight: _____ M F

Diagnosis _____ Date of Onset: _____

Medications: _____

Please indicate if patient has a problem and/or surgical history in any of the folowing areas:*

AREA	Y	N	Comments	AREA	Y	N	Comments
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures**			Type:	Controlled:			Date of Last Seizure:

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No

☐ ☐ Has an x-ray evaulation for atlanto-axial instability been done? DATE of X-RAY _____

☐ ☐ If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old please state the result of the most recent visual examiniation conducted within the past six months:

☐ The client has not had a timely physical examination and so cannot at this point be so certified.

☐ The client's annual physical examination reveals no symptoms of AAI.

☐ The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2. To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Physician's Signature:	Date of Exam:
Physician's Name (please print):	Physician's Phone:
Address:	Fax:

(OVER)

Participant's Medical History and Physician's Statement

SEIZURE DISORDER PARTICIPANTS

PATH (Professional Association of Therapeutic Horsemanship Association) recommends the following information for PATH Operating Centers for riders with seizure disorders:

Would you consider _____'s seizures to be: (please rate)
(name of participant)

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:	
Typical seizure:	
Typical motor activity during seizure:	
Description of client's behavoir during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at Wish Upon a Horse	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and if so, to what degree:

ORTHOPEDIC
Spinal Fusion
Spinal Instabilities/Abnormalities
Alantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization
Disease

NEUROLOGIC
Hydorcephalus/shunt
Spina bifida
Tethered Cord
Chiaril Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

SECONDARY CONCERNS
Behavior Problems
Age under 2 years
Age 2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter

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