PHYSICIAN'S STATEMENT I

Good Hope Equestrian & Regenerative Farm, Inc.

Participant: _____ DOB: _____ Height: _____ Weight*: _____
Participant Address: _____ Participant Phone: _____
Special Precautions Needed: _____
Diagnosis: _____ Date of Onset: _____

This Section MUST Be Complete. ***GHETC horses are unable to carry riders over 250 pounds.***

Past prospective surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____
Shunt Present: Y N Date of last revision: _____
Independent Ambulation: YN Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices: _____
For those with Down Syndrome:
☐ Negative Cervical X-ray for Atlantoaxial Instability date: _____ Result: + -
☐ Negative for clinical symptoms of Atlantoaxial Instability_____
Additional Conditions:
_____
_____

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

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

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (ie: MD, PT, OT, Speech, &/or Psychologist) in the implementing of an effective equestrian program. Therefore, I refer this person to the PATH center for on-going evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____

Phone: ( ) _____ License/UPIN Number: _____

PHYSICIAN'S STATEMENT II
Good Hope Equestrian & Regenerative Farm, Inc.

Dear Health Care Provider:

Your patient _____is interested in participating in supervised equine activities.

Participant's name

In order to safely provide this service, our center requested 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. 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 the center at the address/phone below.

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthosis
Cranial Deficits
Heterotopic Ossification
Joint subluxation/dislocation
Osteoporosis
Pathological fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability
Abnormalities
Amputee

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

Neurologic
Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/Thethered Cord/Hydromyelia
Traumatic Brain Injury

Other
Age – Under 3 years
Indwelling Catheters
Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown
Post Traumatic Stress Disorder

Physician's Notes/Comments:

_____

_____

_____

_____

Physician's Signature _____ Date: _____

Good Hope Equestrian & Regenerative Farm, Inc. 1108 Wild Turkey Run, Halifax, Virginia 24558
office#: (305) 297-4729