sprout
THERAPEUTIC RIDING & EDUCATION CENTER

40685 John Mosby Hwy
Aldie, VA 20105
Phone: 571.367.4555
www.sproutcenter.org

PARTICIPANTS MEDICAL HISTORY/PHYSICIAN RELEASE
****Parents/Guardians, please complete the top of this form****
PLEASE PROVIVDE YOUR PHYSICIAN WITH THE FOLLOWING INFORMATION

Date: _____

Deal Health Care Provider: _____

Your patient _____
Is interested in participating in supervised equine activities. In order to safely provide this service, Sprout Therapeutic Riding and Education Center requests that you complete the attached Medical 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 your patient's participation in equine activities, please feel free to contact the center at info@sproutcenter.org.

Participant: _____ Date:_____

Address: _____

Primary Diagnosis:_____ICD Code: _____

Onset (please check one) [ ]Birth [ ]Childhood [ ]Adolescence [ ]Adult

Secondary_____ ICD Code_____ Tertiary_____ ICD Code_____

Date of Birth_____Current Height_____ Current Weight_____

Tetanus Shot [ ]no [ ]yes Date:_____

PLEASE LIST ALL CURRENT MEDICATIONS

1._____ taken for _____

2._____ taken for _____

3._____ taken for _____

Seizure type _____ Controlled? _____ Date of last seizure_____

Ambulatory: [ ]yes [ ]no Uses: [ ]Crutches [ ]Braces [ ]Cane [ ]Walker [ ]Wheelchair

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Special precautions needed with this student:

_____

_____

Please indicate current or past difficulties in the following systems/areas (including surgeries.)

System/Area	Yes	No	Comments
Allergies (incl. asthma)			
Auditory			
Balance			
Cardiac			
Circulatory (incl. hemophilia)			
Cognitive problems			
Emotional/psychological			
Immunity			
Integumentary/skin			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile sensation			
Visual (including glasses)			
Other			

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The following may suggest precautions or contraindicate therapeutic horseback riding.

Orthopedic	**Medical/Psychological**
Atlantoaxial Instability-include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Cancer
Heterotopic Ossifications/Myositis Ossificans	Cardiac Condition
Internal Spinal Stabilization Device	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Pathological Fractures	Dangerous to Self or Others
Spinal Joint Fusion/Fixation	Exacerbations of medical conditions (e.g. MS, RA)
Spinal Joint Instability/Abnormalities	Fire settings
Neurologic	Hemophilia
Hydrocephalus/Shunt/Shunt revision	Medical Instability
Paralysis Due to Spinal Cord Injury	Migraines
Seizures	Peripheral Vascular Disease
Spinal Bifida/Chiari II Malformation/Tethered Cord/ Hydromyelia	Respiratory Compromise
Stroke	Recent Surgeries
Other	Substance Abuse
Age—under 4 years for therapeutic riding	Thought Control Disorders
Indwelling catheters/medical equipment	Weight Control Disorders
Medication side effects (e.g. photosensitivity)	
Poor endurance	
Skin breakdown	

Please indicate if any of the aforementioned conditions are present and to what degree.

_____

_____

******FOR PERSONS WITH DOWN SYNDROME******

Atlantodens Interval X-Rays: Positive ___ Negative ___ X-Ray Date _____

Neurological symptoms of Atlantoaxial Instability? [ ]Yes [ ]No

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh this medical information against the existing precautions and contraindications. Therefore, I refer this person to the therapeutic riding center for ongoing evaluation to determine eligibility for participation.

Name (Please print):_____ Title: MD DO NP PA Other_____

Signature: _____ Date:_____

Address:_____

Phone:_____ License/UPIN Number:_____