MEDICAL RELEASE FORM

Date: ______________________

Dear Healthcare Provider:

Your patient,___________________________, is interested in participating in the Ride for Joy Therapeutic Riding Program. In order to safely provide this service, we request that you complete the attached paperwork. ***If this patient has Down syndrome or any other condition that predisposes them to Atlantoaxial Instability, please include results of their most recent neurologic exam (must have been within the last year).***

The following conditions may suggest precautions and contraindications to equine activities. When completing this form, please note whether these conditions are present and, if so, 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
Sensory Deficit
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 Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you for your assistance. If you have any questions about therapeutic riding activities, please email lpekovich@rideforjoy.org.

Sincerely,

Lucy Pekovich
Ride for Joy Program Coordinator

Participant Name: ____________________

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 patients with Down Syndrome: AtlantoDens Interval X-rays Date: ______ Result + -
Were neurologic symptoms of AtlantoAxial Instability present at this visit? Y N Date: ______
If yes, symptoms observed were**:** ____________________

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

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			

	Y	N	Comments
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities. I understand that Ride for Joy will weigh the medical information provided against the existing precautions and contraindications. Therefore, I refer this person to Ride for Joy for ongoing evaluation to determine eligibility for participation.

Name/Title:______________________________ MD DO NP PA Other __________

Signature:______________________________ Date: ________________

Address: ____

Phone:______________ License/UPIN Number: ______________________

PLEASE FAX THIS FORM TO:
1-208-550-3208