RIDE WITH PRIDE, INC.

P.O. Box 1203, Staunton, VA 24402-1203

RIDER'S MEDICAL HISTORY and PHYSICIAN'S STATEMENT

To be completed annually by a physician

Name of Participant: _____ Date of Birth: _____

Address: _____

Height _____ Weight _____ Tetnus Shot: Yes _____ No _____ Date _____

Parent/Guardian/Care Taker: _____ Phone: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries:_____

For persons with Down's Syndrome:

Cervical X-ray for Atlanto Dens Interval X-ray: Positive _____ Negative _____ X-ray Date_____

Neurologic symptoms of Atlanto Axial Instability: Present _____ Absent _____

Seizure Type: _____ Controlled: Yes____ No____ Date of Last Seizure_____

Shunt Present: Yes _____ No _____ Date of last revision:_____

Medications: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile			
Speech			
Cardiac			
Circulatory			
Integumentary Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychosocial			
Pain			
Other			

Mobility: Independent Ambulation Yes _____ No _____; Assisted Ambulation Yes____ No___

Braces/Assistive Devices:_____ Wheelchair Yes _____ No _____

Please indicate any special precautions/needs: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding 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 in the implementing of an effective equestrian program.

Physician name/Title *(please print)* _____ MD, DO, NP, PA, Other_____

Physician Signature _____ License/UPIN number:_____

Address _____ City _____

State _____ Zip _____ Phone _____ Date _____