Return to: RWP Program Director
2435 Shutterlee Mill Rd
Staunton, VA 24401

# PHYSICIAN'S STATEMENT and RIDER MEDICAL HISTORY

*To be completed annually by a physician and combined with yearly physical.*

Name of Participant: _____ D.O.B. _____ Age: ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Height _____ Weight _____

Tetanus Shot (Date): _____

Diagnosis: _____ Date of Onset: _____

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

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

Medications: _____

Past/Prospective Surgeries: _____

Please indicate current or past special needs and/or surgeries in any of the following areas by checking yes or no

| Areas | Yes | No | If YES, please comment |
|---|---|---|---|
| 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: Yes_____ No _____ Wheelchair Yes _____ No _____

Please indicate any special precautions/needs:

_____

For persons with Down Syndrome:

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

Neurologic symptoms of Atlanto Axial Instability: Present _____ Absent ____

**Physicians Statement:** 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, _____

Physician Signature _____ License/UPIN number: _____

Address: _____ or *Stamp Here:*

City: _____ State: _____ Zip Code: _____