CTRH Participant's Medical History & Physician's Statement 2021

THIS FORM MUST BE COMPLETED ANNUALLY TO BE CONSIDERED FOR PARTICIPATION

Participant Information (to be filled out by Participant/Parent/Caregiver)

Applicant's Name: ______________________________ Nickname: ___________________________________

Age: _______ (minimum age: 2 1/2 - HPOT; 5 - Recreational Riding) Birthdate: ________ Gender: _______

Address: ____
Street City State Zip

Parent/Guardian/Caregiver Name(s): ____ Phone: ____________________

Emergency Contact: ____ Phone: ____________________

Primary Physician: ____

Participant Medical Information (to be filled out by Physician)

Diagnosis:____________________________________

Weight: _______lbs. (175 lb. limit to ride)

Height: ________

Tetanus Shot: ___ No ___ Yes - Date: ________

Normal Blood Pressure: _______

Normal Temperature: _______

Complete both sections for participants with Down syndrome:

Neurologic symptoms of Atlantoaxial Instability

________ **Exam date** ________**negative** ________ **positive**

!!Neurologic exam must be completed every calendar year!!

Cervical X-Ray for Atlantoaxial Instability ______ **X-ray date:** ____________

________**negative** ________ **positive**

Medications: ____

Past medical history, problems, and/or surgeries

	Yes	No	Comments
Auditory	_____	_____	____
Visual	_____	_____	____
Speech	_____	_____	____
Cardiac	_____	_____	____
Circulatory	_____	_____	____
Pulmonary	_____	_____	____
Neurological	_____	_____	____
Muscular	_____	_____	____
Orthopedic	_____	_____	____
Allergies	_____	_____	____
Learning Disability	_____	_____	____
Mental Impairment	_____	_____	____
Psychological Impairment	_____	_____	____
Seizure Disorder	_____	_____	____
Controlled	_____	_____	Date of last seizure: ____________________________

Mobility Status

___ Independent _____ Walker _____ Cane _____ Crutches _____ Wheelchair

Transfer Ability: ____

Completed Form Can Be Returned Directly to CTRH - Secure Fax 844-716-2708

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Information for Physician

The following conditions, if present, may represent precautions or contraindications to hippotherapy and/or therapeutic riding. **Please indicate whether these conditions are present and to what degree.**

Orthopedic

Spinal Fusion
Spinal Instabilities / Abnormalities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation / Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices
Atlantoaxial Instability - include neurologic symptoms

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Cardiac Condition
Stroke

Neurologic

Hydrocephalus / Shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns

Behavior Problem
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

**** PHYSICIANS PLEASE TAKE NOTE: If approving for Hippotherapy, a signature is REQUIRED in BOTH boxes below. ****

Physician's Statement for All Participants:

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

Physician's Name (Please Print): ________________________________ Phone: ___________________

Physician's Signature: ____ Date: ____________________

Address: ____
Street City State Zip

Prescription for Hippotherapy Participants Only:

Prescription for occupational, speech therapy, and physical therapy utilizing hippotherapy as a therapeutic strategy. Functional goals will integrate improvement with balance, strength, posture, communication, and activities of daily living.

Physician's Signature: _________________________ Physician's Name: ______________________________

CTRH
Cincinnati Therapeutic Riding and Horsemanship

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