Participant’s Medical History & Physician’s Statement

Participant: 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 those with Down syndrome:* Neurologic Symptoms of Atlantoaxial Instability:  Present  Absent

***Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.***

Circulatory

Integumentary/Skin

Immunity

Pulmonary

Neurologic

PATH Intl. Standards for Certification & Accreditation

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Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: MD DO NP PA Other Signature: Date: Address:

Phone: ( ) License/UPIN Number:

Y

N

Comments

Auditory

Visual

Tactile Sensation

Speech

Cardiac

Muscular

Balance

Orthopedic

Allergies

Learning Disability

Cognitive

Emotional/Psychological

Pain