



LOVE for Therapeutic Riding

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Tax ID 26-2965095
a faith-based, non-profit program



Special Olympics
South Carolina



RIDER Medical History & Physicians' Statement (PAGE 1 OF 2)

Participant Name:	Date of Birth:	Sex:	Race:	Height	Weight:
Name / Address of Guardian:			Tetanus Shot:	YES	NO
Diagnosis:			Date:	Date of Onset:	
Medications:					

Please indicate if patient has a problem and/or surgical history in any of the following areas:

AREA	YES	NO	COMMENTS	AREA	YES	NO	COMMENTS
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures			Type:	Controlled:			Date of Last Seizure:

**** Please complete required information on page 2 for SEIZURE patients ** See Page 2 for list of precautions and contraindications**

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No

Has an x-ray evaluation for atlanto-axial instability been done? DATE of X-RAY _____

If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

If this X-Ray is more than 1 year old Please state the result of the most recent visual examination conducted within the past six months:

The client has not had a timely physical examination and so cannot at this point be so certified.

The client's annual physical examination reveals no symptoms of AAI

The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

I have reviewed the attached list of conditions which may present precautions and contraindications to therapeutic horseback riding on page 2, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities:

Physician's signature _____ Date of Exam: _____

Physician's Name (print) _____ Physician's Phone: _____

Address: _____ Physician's Fax: _____

RIDER Medical History & Physicians' Statement
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SEIZURE DISORDER PARTICIPANTS

NARHA, recommends the following information for NARHA Operating Centers for riders with seizure disorders.
 Would you consider _____'s seizures to be:

- Completely controlled Very well controlled Fairly controlled by medication

Type of seizure:	
Typical aura:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:
Specific directions as to what to do if a seizure should occur at LOVE for TR:	
Physician's Signature	Date:

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and, if so, to what degree.

ORTHOPEDIC

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Alantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Internal Spinal Stabilization Disease

NEUROLOGIC

- Hydrocephalus/shunt
- Spina bifida
- Tethered Cord
- Chiari I Malformation
- Hydromyelia
- Paralysis due to Spinal Cord
- Injury
- Seizure Disorders

SECONDARY CONCERNS

- Behavior Problems
- Age under 4 years
- Age 4-5 years
- Acute exacerbation of chronic disorder
- Indwelling catheter

MEDICAL/SURGICAL

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Hypertension
- Serious Heart Condition
- Stroke (Cerebrovascular)
- Accident