



*RISING HOPE FARMS*  
*EQUINE ASSISTED ACTIVITIES & THERAPY*  
*3775 BETHANY CHURCH ROAD*  
*CLAREMONT, NC 28610*

Date: \_\_\_\_\_

Dear Health Care Provider:

Your patient, \_\_\_\_\_  
(participant's name)

is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

Atlantoaxial Instability-include neurologic symptoms  
Coxa Arhrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spinal Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

**Other**

Age – under 3 years  
Indwelling Catheters/Medical Equipment  
Medications – i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

**Medical/Psychological**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions (i.e. RA MS)  
fire Settings  
Hemophilia  
Migraines  
PVD  
Respiratory Compromise  
Recent surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concern regarding this patient is participation in equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,