



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

## 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:* AtlantoDens Interval X-rays, date \_\_\_\_\_ Result: + -  
 Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Rising Hope Farms will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Rising Hope Farms for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_