RISING 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: + -
NeurologicSymptoms 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: _____