Horse SenseAbility
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PHYSICIAN STATEMENT

Participant: _____ DOB: ____/_____/_____

Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Date of Onset: _____/_____/_____

Past/Prospective Surgeries: _____

Medications: _____

_____

Seizure Type: _____ Controlled: ___ YES ___ N0

Date of Last Seizure: _____/_____/_____

Shunt Present: ___ YES ___ N0 Date of last revision: ____/_____/_____

Special Precautions/Needs: _____

_____

Independent Ambulation: ___ YES ___ N0 Assisted Ambulation: ___ YES ___ N0

Wheelchair: ___ YES ___ N0 Braces/Assistive Devices: _____

Neurologic Symptoms of AtlantoAxial Instability (for those with Down Syndrome:

_____

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

Signature: _____ Date: _____/_____/_____

Name: _____ License/UPIN Number _____

Address: _____

Phone: _____