# Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____

Shunt Present: _____ Controlled: Y N Date of Last Seizure: _____

Developmentally Delayed: Y N DD Age: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair : Y N

Braces/Assistive Devices: _____

***For those with Down Syndrome*: Neurologic Symptoms of Atlantoaxial Instability:** Present ☐ Absent ☐

***Please indicate current or past special needs in the following systems/areas, including surgeries.***
***These conditions may suggest precautions and contraindications to equine activities.***

| | Y | N | Comments |
|---|---|---|---|
| AuditoryTactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/ Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

**Given the above diagnosis and medical information, this person is medically able to participate in equine-assisted services. I understand that If Wishes Were Horses Foundation will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to If Wishes Were Horses Foundation for ongoing evaluation to determine eligability for participation.**

**Name/Title:** _____ **MD DO NP PA**

**Signature:** _____ **Date:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone:(** _____ **)** _____ **-** _____ **License/UPIN Number:** _____