Galloping Acres Foundation, Inc. & Hanover County Parks & Recreation Therapeutic Riding Program

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 difficulties in the following system/area, including surgeries:

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

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. **However, I understand that Hanover County Parks and Recreation will weigh the medical information above against the existing precautions and contraindications.**
Name/Title: _____ MD DO NP PA Other _____
Signature: _____ DATE: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____

Date: _____

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities provided by Galloping Acres Foundation, Inc & Hanover County Parks & Recreation Department. This program is accredited by the Professional Association of Therapeutic Horsemanship Intl. (P.A.T.H.) as a member center.

In order to safely provide this service, we request 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

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

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Other
Age- under 4 years
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migranes
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 concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact Shannon Lawson at 883-3003

Sincerely,

Shannon Lawson

Shannon Lawson

Program Director
Certified Professional Association Therapeutic Horsemanship Intl. (P.A.T.H.) Registered Instructor

Participant's Application and Health History for the Therapeutic Riding Program

General Information

Participant: _____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____
Phone: _____ (H) _____ (W) _____(Cell or Pager #).

Employer/School: _____
Address: _____
Phone: _____

Parent/Legal Guardian: _____
Address (if different from above): _____
Phone: _____ (H) _____ (W) _____ (Cell or Pager #).

How did you hear about the Therapeutic Riding Program? _____

Health History

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other:			

What medications are you currently taking, including over – the – counter medications? _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

FUNCTION: (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL: (i.e. Work/school including grade completed, leisure interests, relationships-family structure, Support systems, companion animals, fears/concerns, etc.)

GOALS: (i.e. Why are you applying for participation? What would you like to accomplish?)

PHOTO RELEASE

I _____ **DO**

_____ **DO NOT**

consent to and authorize the use and reproduction by Hanover County Parks and Recreation of any and all photographs and any other audio/visual materials taken of the participant for promotional material, educational activities, exhibitions or for any other use for the benefit of the Therapeutic Riding program.

SIGNATURE: _____ Date: _____

Client, Parent or Legal Guardian