Joy & strength through horses
HorseFriends
Therapeutic Riding Program

Date: _____

Dear Health Care Provider:
Your patient, _____
(participant's name)
is interested in participating in supervised equine activities at HorseFriends, Inc., a therapeutic riding program.

In order to safely provide this service, our center requests 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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

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

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies Animal
Abuse Cardiac
Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
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 equine-assisted activities, please feel free to contact me at HorseFriends 336-420-4588.

Sincerely,

Mandy Crews, Operations & Program Director
HorseFriends, Inc.
336-420-4588
MandyCrews@HorseFriendsNC.org www.HorseFriendsNC.org

(rev. 4/2020)