



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 at 336-420-4588.

Sincerely,

Laura Michael

HorseFriends, Inc.

336-420-4588