GIANT STEPS
Therapeutic Equestrian Center
1390 N. McDowell Blvd, Suite G #331 Petaluma, CA 94954
Office Phone: (707) 769-8900 Program Phone: (707) 781-9455 Facsimile (707) 769-4770

Dear Physician:

One of your patients is interested in participating in supervised equestrian activities.

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 present precautions or contraindications to adaptive horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic:
- Atlantoaxial Instability-include neurologic symptoms
- Contractures
- Coxa Arthrosis
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Instability/Abnormalities
- Spinal Fusion/Fixation
- Scoliosis 30 degrees or greater

Neurologic:
- Hydrocephalus/Shunt
- Neuromuscular Disorders (if pain or fatigue increases with the activity)
- Uncontrolled Seizures
- Tethered Cord Symptoms Chiari II Malformations, Hydromyelia Symptoms (all are associated with Spina Bifida)
- Spinal Cord Injury (contraindication if injury is above T-6)

Medical/ Psychological:
- Allergies
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Hemophilia
- Medical instability
- PVD
- Respiratory Compromise

Other:
- Age: under 4 years
- Indwelling Catheters
- Medications – i.e., photosensitivity
- Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic riding activities, please feel free to contact me by phone at 707-781-9455 or by email at julie@giantstepsriding.org.

Sincerely,

Julie Larson
Program Director

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Physician Assessment

(This form must be completed in full and signed by **participant's physician**)

Patient's Name: _____ Parents/Guardian: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____

Diagnosis: _____

Hospitalization/Surgery (Dates & Reasons): _____

Medications: _____

Shunts/Implants/Appliances: _____

Ambulatory status: _____

Is a Seizure Disorder present? _____ Controlled? _____ Date of last seizure: _____

Seizure Type: _____

Please Indicate And Comment On Any Special Problem Areas Below:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological/Sensation			
Muscular			
Orthopedic			
Bowel/Bladder			
Allergies			
Cognition			
Psychological			
Behavior			
Amputations			
Other			

Please indicate any special precautions/contraindications to adaptive horseback riding: _____

_____

_____

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Physician Release

To my knowledge there is no reason why _____
(Patient's Name)
cannot participate in supervised equestrian activities. However, I understand that Giant Steps Therapeutic Equestrian Center will weigh the medical information contained in the physician release form against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

*****Mandatory for Persons with Down Syndrome*****

Cervical X-Ray for Atlantoaxial Instability: Positive: _____ Negative: _____ X-Ray Date: / /

PATH International standards require that all participants with Down Syndrome provide **annual** proof of a neurologic exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI). Please provide the following:

Date of last neurologic exam: / /

Symptoms of atlantoaxial instability (AAI) present? Yes _____ No _____
(please check one)

Physician's Signature: _____ Date: _____

Physician's name, address & telephone number (please print, type or stamp):

_____

_____

_____

_____