Physician's Statement & Medical History

****Must be Completed by a Medical Provider****

Participant: _____DOB: _____ Height: _____ Weight: _____lbs

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Special Precautions/Needs: _____

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

Braces or Assisted 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:

Systems/ areas	Y	N	Comments
Seizure Type: _____			Controlled: Y/ N Date of last: _____
Shunt Present			Date of last revision:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/ Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/ Psychological			
Pain			
Other			

Given the above diagnosis and medical information, there is no reason why this person is not medically precluded from participation in equine-assisted services. I understand that the Camp Red Cedar will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the equine center for ongoing evaluation to determined eligibility for participation.

Physician Name and title (please print) _____ MD DO NP PA

Physician Signature _____ Date: _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ License/UPIN Number: _____