PHYSICIAN RELEASE

(ALL NEW PARTICIPANTS MUST HAVE THIS FORM COMPLETED PRIOR TO PARTICIPATING IN EQUINE ASSISTED ACTIVITIES)

TO PHYSICIAN COMPLETING RELEASE,

This person is registering to participate in Equine Assisted Activities and Therapies. Horseback riding has inherent risks; however, some medical conditions are contraindicated due to the balance and trunk control required. Please consider this when completing this form.

Name: _____Date of Birth: _____ Age: _____

Name of Parent/Guardian: _____

Primary Diagnosis: _____Date of Onset: _____

Secondary Diagnosis: _____

Height ___ft ___in Weight _____ lbs. Date of Last Tetanus Shot: _____

Down Syndrome: Neurological Symptoms of Atlantoaxial Instability: Present_____ Absent_____
Date of AI testing: _____ Result: _____

Please Mark All That Apply To this Patient

Asthma	Inhaler	EpiPen	Allergies - Type	
Independent Ambulation	Walker	Wheelchair	Brace - Type=	Catheter Type=

For Patients Who Use a Wheelchair, Please Circle

Wheelchair Only Aids Ambulation Sometimes	Sits Up Unassisted
Support Through Trunk Required	Full Support of Head and Neck Required

Please Indicate All Areas Involved

	Description
Cardiovascular	
Spinal Condition i.e., Spina Bifida, Scoliosis, Fusion, Injury	
Medical Device Implanted (insulin pump, catheter, colostomy)	
Diabetes	
Musculoskeletal – Body Part	
Bleeding or clotting disorders	
Neurological condition	

Mental Health Crisis	
Pulmonary condition	
Have altered sensation? (specify)	

For Patient's with a History of Seizures

Date of Last Seizures _____ Frequency of Seizures _____

Type of Seizures _____

Typical Causes of Seizure Activity _____

_____

How does Seizure Present _____

_____

TO BE COMPLETED BY PHYSICIAN ONLY

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand The Therapeutic Riding Institute will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to The Therapeutic Riding Institute for ongoing evaluation to determine eligibility for participation.

□ I Agree There Are No Contraindications to Mounted Riding Lessons
□ Mounted Riding Lessons is NOT Recommended, but Unmounted Lessons are Not Limited
□ Restrictions include _____

_____

Physician name (please print) _____

Physician Signature _____Date _____

Medical Practice Name _____

Address _____

City_____ State _____ Zip _____

Phone_____ Fax _____

Please Return Completed Form to Participant or
TRI
3960 Middle Run Road, Spring Valley, OH 45370
Email to: KCorbett@TRIOhio.org