SHAR *Introduction to Physician*

Date: _____

Patient Name: _____, is interested in participating in supervised
(Rider's Name)
equine activities at ***Shady Hollow Assisted Riding***.

In order to safely provide this service, our center requests that you complete 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 Cord/Hydromyelia

Other

Age– Under 4 years

Indwelling Catheters/Medical Equipment

Medication– 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

Exacerbation sof 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 services, please feel free to contact ***Shady Hollow Assisted Riding***.

Shady Hollow Assisted Riding
959 E Main St
Birdsboro, PA 19508
www.hugahorse.com

SHAR MEDICAL HISTORY & PHYSICIAN'S STATEMANT

Name:_____DOB:___/___/____

Age:____ Sex:____ Height:_____ Weight:_____ Diagnosis: _____

Medications (Type/Purpose): _____

_____

Seizure: Type: _____ Controlled Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present ___ Absent ___

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

Braces/Assisitve Devices: _____

Problem	Yes	No	Comments
Auditory			
Speech			
Visual			
Emotional			
Psychological			
Learning Disability			
Immunity			
Allergies			
Cardiac			
Circulatory			
Pulmonary			
Asthma/COPD			
Neurological			
Sensory Loss			
Pain			
Muscular			
Contractures			
Others			

*Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted services. I understand that **Shady Hollow Assisted Riding** will weigh the medical information given against the existing Precautions and contraindications. Therefore, I refer this person to **Shady Hollow Assisted Riding** for ongoing evaluation to determine eligibility for participations.*

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____