Participant's Medical History and Physician's Statement

Participant: ________________________________ DOB:__________ Height:___________ Weight:_____________

Address:____

Diagnosis:____________________________________ Date of Onset:______________________________

Past/ProspectiveSurgeries:____

Medications:____

Seizure Type: ______________________ Controlled: **Y N** Date of last seizure: ___________________

Shunt Present: **Y N** Date of last revision:______________________________________

Special Precautions/Needs:____

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

Braces/Assistive Devices: ____

For those with Down Syndrome: AtlantoDens Interval X-ray, Date: __________ Result: **+ –**

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 past surgeries:

	Y	*N*	*COMMENTS*
Auditory			
Visual			
Tactile			
Speech			
Cardiac			
Circulatory			
IntegumentarySkin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychosocial			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____________________________________ **MD DO NP PA Other** ___________________

Signature:____ **DATE**: ____________________

Address: ____**ZIP**: __________________

Phone: ____ **License/UPIN Number**:_______________

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