



Participant's Medical History and Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 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 individuals with Down Syndrome: AtlantoDens Interval X-ray, Date: _____ Result: + -

For individuals 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:

	<i>Y</i>	<i>N</i>	<i>COMMENTS</i>
<i>Auditory</i>			
<i>Visual</i>			
<i>Tactile</i>			
<i>Speech</i>			
<i>Cardiac</i>			
<i>Circulatory</i>			
<i>Integumentary/Skin</i>			
<i>Immunity</i>			
<i>Pulmonary</i>			
<i>Neurologic</i>			
<i>Muscular</i>			
<i>Balance</i>			
<i>Orthopedic</i>			
<i>Allergies</i>			
<i>Learning Disability</i>			
<i>Cognitive</i>			
<i>Emotional/Psychosocial</i>			
<i>Pain</i>			
<i>Other</i>			

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: _____

PATH Accreditation Standards 2021