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 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:

	Y	*N*	*COMMENTS*
Auditory			
Visual			
Tactile			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
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**:_____

PATH Accreditation Standards 2021