Safe Haven Equine Assisted Activities

Safe Haven Farms, 5970 No Man's Road, Middletown, OH 45042

Participant's Medical History and Physician's Statement

Must be completed by a Physician

Patient : _____ DOB: _____ Name of Guardian: _____

Female □ Male □

Height: _____ Weight: _____ Tetanus Shot Date: _____

Primary Diagnosis _____Secondary Dx_____ Other _____

Medications that may affect balance, strength, behavior: Yes □ No □ Sun Sensitivity: Yes □ No □

Please indicate if patient has a problem and/or surgical history in any of the following areas:*

AREA	Y	N	Comments	AREA	Y	N	Comments
Auditory				Muscular			
Visual				Independent Ambulation			
Speech				Crutches			
Allergies				Braces			
Cardiac				Wheelchair			
Circulatory				Neurological			
Learning Disability				Orthopedic			
Mental Impairment				Pulmonary			
Psychological Impairment				Other			
Seizures**			Type:	Controlled:			Date of Last Seizure:

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR PATIENTS WITH DOWN SYNDROME

If the patient has Down syndrome a full radiological examination establishing the absence of Atlanto-axial Instability is REQUIRED before they may participate in equestrian activities which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes No

☐ ☐ Has an x-ray evaulation for atlanto-axial instability been done? DATE of X-RAY _____

☐ ☐ The client's annual physical examination reveals no symptoms of AAI.

☐ ☐ The client's annual physical examination shows symptoms of AAI. Riding is CONTRAINDICATED.

Seizures do not automatically excuse a person from riding. Participant must not have had a Grand Mal seizure within the past 12 months. The nature of the seizure and how it presents must be considered prior to mounting a horse.

DOES THIE PATIENT HAVE A HISTORY OF SEIZURES? □ Yes □ No □ Unknown

Would you consider these seizures to be (please rate)?

☐ Completely controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure:	
Typical seizure:	
Typical motor activity during seizure:	
Description of client's behavior during post-ictal state:	Post-ictal state duration:

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The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and if so, to what degree:

□ Spinal Fusion	□ Heterotopic Ossification	□ Hypertension
□ Spinal Instabilities/Abnormalities	□ Osteogenesis Imperfecta	□ Serious Heart Condition
□ Atlantoaxial Instabilities	□ Cranial Deficits	□ Stroke (Cerebrovascular)
□ Scoliosis	□ Spinal Orthoses	□ Recent Physical Accident
□ Kyphosis	□ Internal Spinal Stabilization Disease	□ Tethered Cord
□ Lordosis	□ Hydorcephalus/shunt	□ Chiaril Malformation
□ Hip Subluxation and Dislocation	□ Spina bifida	□ Hydromyelia
□ Osteoporosis	□ Peripheral Vascular Disease	□ Hypertension
□ Pathological Fractures	□ Varicose Veins	□ Serious Heart Condition
□ Coaxes Arthrosis	□ Hemophilia	□ Stroke (Cerebrovascular)
□ Seizure Disorders	□ Fire Starter	□ Cancer
□ Aggressive Behaviors	□ Self Harm	□ Poor Endurance
□ Age under 5 years	□ PICA	□ Recent Surgery
	□ Incontinence	□ Diabetes
□ Paralysis due to Spinal Cord Injury	□ Fire Starter	□ Cancer
□ Indwelling catheter	□ Self Harm	□ Poor Endurance

Other: _____

_____

I have reviewed this patient's medical history. To my knowledge,

□ There are no obvious medical reasons this person cannot participate in equine assisted activities.

□ This person may participate in equine assisted activities with the following precautions:

_____

□ There are too many contraindications to safely participating in equine assisted activities due to the following:

_____

Physician's Signature:	**Date of Exam:**
Physician's Name (please print):	Physician's Phone:
Address:	Fax:

PLEASE RETURN THIS FORM TO PATIENT OR THEIR GUARDIAN. IT MAY BE SENT DIRECTLY TO SAFE HAVEN FARMS, c/o Equestrian Program, 5970 No Man's Road, Middletown, OH 45042

Safe Haven Farms
A Community of Choice