

PARTICIPANT APPLICATION

PHYSICIAN'S RELEASE FORM - REQUIRED*



PLEASE RETURN TO: program@jhtr.org | Fax: 307.732.0212 | PO Box 415 Teton Village, WY 83025

*This form must be completed by a licensed medical provider prior to participation. Valid for 12 months unless the participant experiences a significant medical change.

PARTICIPANT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

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

Shunt Present: Y N Date of Last Revision: _____ Braces/Mobility Devices: _____

HEALTH HISTORY CHECKLIST

Please indicate any history of medical conditions/concerns. Certain conditions may suggest precautions/contraindications for participation.

Medical Category	Y	Comments
Cardiovascular		
Pulmonary / Respiratory		
Neurological		
Musculoskeletal / Orthopedic		
Cognitive / Psychological		
Sensory (Vision / Hearing)		
Mobility / Balance / Motor Control		
Metabolic / Systemic		
Behavioral / Safety Considerations		
Allergies / Environmental Sensitivities		
Skin Integrity / Medical Devices		
Past/Prospective Surgeries		
Other		

FOR PATIENTS WITH DOWN SYNDROME - A NEUROLOGIC EXAM MUST BE COMPLETED ANNUALLY

Date of last neurologic exam: _____ Neurologic Symptoms of Atlantoaxial Instability*: Present Absent

*Individuals must have **NO symptoms of Atlantoaxial Instability (AAI)** to participate in mounted activities.

PHYSICIAN'S RELEASE

Given the above information, this patient is **not** medically precluded from participating in equine assisted services. I understand that JHTR will weigh the medical information provided against the existing precautions and contraindications. Therefore, I refer this person to JHTR for ongoing evaluation to determine eligibility for participation.

Name: _____ Provider Type: _____ License/UPIN #: _____

Signature: _____ Date: _____ Phone: _____