MEDICAL RELEASE FORM

Date: _____

Dear Healthcare Provider:

Your patient,_____, is interested in participating in the Ride for Joy Therapeutic Riding Program. In order to safely provide this service, we request that you complete the attached paperwork. ***If this patient has Down syndrome or any other condition that predisposes them to Atlantoaxial Instability, please include results of their most recent neurologic exam (must have been within the last year).***

The following conditions may suggest precautions and contraindications to equine activities. When completing this form, please note whether these conditions are present and, if so, to what degree.

Orthopedic
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you for your assistance. If you have any questions about therapeutic riding activities, please email lpekovich@rideforjoy.org.

Sincerely,

Lucy Pekovich
Ride for Joy Program Coordinator

RIDE for JOY

Participant Name: _____

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 patients with Down Syndrome:

A complete neurologic exam is required annually for individuals with Down Syndrome.

Were symptoms of Atlantoaxial Instability, focal neurologic disorder, or a decrease in neurologic function present at this visit? Y N Date of neurologic exam: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			

	Y	N	Comments
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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

Name/Title:_____ MD DO NP PA Other _____

Signature:_____ Date: _____

Address: _____

Phone:_____ License/UPIN Number: _____

PLEASE FAX THIS FORM TO:
1-208-550-3208