KAP Equine Services Corp

**Rider's Medical History and Physician Statement**

Before being accepted as a rider, it is essential that the questions are thoroughly and completely answered so each rider's abilities and limitations are given due consideration by KAP Equine Services Corp trained instructors, the student's physicians and therapists.

Rider's Name: _____ Birth Date: _____ Age: ___

Diagnosis: _____ Date of Onset: _____

Shunt: Y / N Date of last revision: _____

Tetanus shot: Y / N Date of shot: _____

Seizures: Y / N Controlled: Y / N Date of last seizure: _____

***For persons with Down Syndrome**

Cervical x-ray for Atlantoaxial Instability

Positive _____ Negative _____ Date of x-ray _____

Specific body movements or positions **NOT** to be attempted _____

_____

_____

Specific body movements or positions desired _____

_____

_____

**TO THE PHYSICIAN:** Please indicate if patient has a problem and/or surgeries in any of the following areas by circling yes or no. If yes, please provide a comment.

Auditory: Y / N _____

Visual: Y / N _____

Tactile Sensation: Y / N _____

Speech: Y / N _____

Cardiac: Y / N _____

Circulatory: Y / N _____

Integumentary/Skin: Y / N _____

Immunity: Y / N _____

Pulmonary: Y / N _____

Neurological: Y / N _____

Muscular: Y / N _____

Balance: Y / N _____

Orthopedic: Y / N _____

Allergies: Y / N _____

## KAP Equine Services Corp

### Rider's Medical History and Physician Statement

Learning Disability: Y / N _____

Mental Improvement: Y / N _____

Psychological Impairment: Y / N _____

Pain: Y / N _____

Other: Y / N _____

To my knowledge, there is no reason why this patient cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information provided against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of any effective equestrian/hippotherapy program.

**THIS FORM MUST BE SIGNED BY THE ATTENDING PHYSICIAN. WE CANNOT ACCEPT A SIGNATURE STAMP OR THE SIGNATURE OF ANY THERAPIST, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER.**

**THIS SIGNATURE MUST BE ORIGINAL. A FAX CANNOT BE ACCEPTED.**

Physician's Name: _____ Date: _____

(Please Print)

Physician's Signature: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

**THIS FORM IS VALID FOR A PERIOD OF ONE (1) YEAR FROM DATE SIGNED**

If you have any further concerns about this patient participating in Therapeutic Riding sessions, please specify: