

Stable Movements
18 SMITHHILL RD.
BINGHAMTON, NEW YORK 13905
607-727-7602

Date: _____

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.
(*participant's name*)

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

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

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurologic

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

Other

Age - under 4 years
Indwelling Catheters
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Theresa Pedrosa
Director @ Stable Movements

Stable Movements
18 Smith Hill rd
Binghamton, NY 13905

Participant's Medical History & Physician's Statement

Participant: _____ 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 those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --
Neurologic Symptoms of AtlantoAxial Instability: _____

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

Auditory
Visual
Tactile Sensation
Speech
Cardiac
Circulatory
Integumentary/Skin
Immunity
Pulmonary
Neurologic
Muscular
Balance
Orthopedic
Allergies
Learning Disability
Cognitive
Emotional/Psychological
Pain
Other

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Stable Movements will weigh the medical information above against the existing precautions and contraindications.

I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____

Phone: () _____ License/UPIN Number: _____

