Information for Physicians:
The following conditions, if present, may represent precautions or contraindications to Therapeutic horseback riding. Therefore, when completing the form on the attached sheet, please note whether these conditions are present and to what degree.

Orthopedic Medical/Surgical
Atlantoaxial Instabilities
Allergies
Coxas Arthrosis
Cancer
Cranial Deficits
Diabetes
Heterotopic Ossification
Hemophilia
Hip Subluxation and Dislocation
Hypertension
Internal Spinal Stabilization Devices
Peripheral Vascular Disease
Kyphosis
Poor Endurance
Lordosis
Recent Surgery
Osteogenesis Imperfecta
Serious Heart Condition
Osteoporosis
Stroke (Cerebrovascular Accident)
Pathologic Fractures
Varicose Veins
Scoliosis Spinal
Orthoses
Spinal Fusion
Spinal Instabilities/Abnormalities

Neurologic Secondary Concerns
Chiari II Malformation
Acute exacerbation of chronic disorder
Hydrocephalus/shunt
Tethered Cord
Hydromyelia
Age under two years
Paralysis due to Spinal Cord injury
Behavior problems
Seizure Disorders
Indwelling catheter
Spina Bifida
Rider’s Medical History and Physician’s Statement

Rider’s Name ______________________________________________________________
Name of Parent/Guardian ____________________________________________________
Diagnosis__________________________________________________________________
Date of Onset________________
Tetanus Shot: (check one) YES/Date ___________ NO __________
Height ________ Weight ________ lbs.
Seizure Type ________________ Controlled? _______ Date of last seizure_____________
Medications_______________________________________________________________
_________________________________________________________________________

Only For Persons with Down Syndrome
Negative Cervical X-ray for Atlantoaxial Instability. Date of X-ray _________________

FOR ALL RIDERS: Please indicate if patient has a problem and/or surgeries in any of the following areas
by circling the items. If yes, please comment.
Auditory                                                Neurological
Visual                                                  Muscular
Speech                                                  Orthopedic
Cardiac                                                  Allergies
Circulatory                                             Learning Disability
Pulmonary                                               Mental Impairment
Psychological impairment                   Other
Mobility: Independent Ambulation ______Yes ______No Crutches ______Yes ______ No
Braces ______Yes ______  No Wheelchair _______ Yes ______ No

Please indicate any special precautions:________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information given 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, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) _____________________ ____________ Date _____________
Physician Signature _______________________________ _____________________________
Address ______________________________________ Phone ( ) ___________________

Physician’s Prescription
Rider’s Name _________________________________
Phone _______________________________________
Diagnosis: __________________________________

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Let’s Saddle Up.

Precautions (all riders must wear helmets)
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Physician’s Signature _________________________________
Date _____________

Please Print, Type or Stamp

Physician’s Name _________________________________________________________
Address ___________________________________________ ______________________
Phone _____________________________________________ _____________________