



Mounted Dream Center, INC.
 P.O. Box 854 Sonora, California 95370
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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries/Dates: _____

Medications: _____

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

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Assisted Ambulation Wheelchair/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 N Comments
- 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 Mounted Dream Center will weigh the medical information above against the existing precautions and contra indications. 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: _____
 Phone: _____ License/UPIN Number: _____

Health Care Provider Request Form

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.

Please attach any helpful history or documentation.

Orthopedic Medical/Psychological

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 Instability

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart conditions
Hemophilia

Neurologic

Hydrocephalus/Shunt
Seizure
Substance Abuse
Thought Control Disorders
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

PVD
Respiratory Compromise
Recent Surgeries
Migraines

Other Weight Control Disorder

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

Areas of concern: _____

Specific recommendations: _____

(Please add additional sheets if needed)

Physician's Signature _____ **Date** _____

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.