Free Rein Therapeutic Riding and Horsemanship Program
PO Box 30893
Spokane WA, 99223
509-979-1468
freereinprogram@hotmail.com
www.freereinspokane.org

Participant Medical History and Physician Release

This form must be updated annually and submitted with required signatures

This medical history form and accompanying physician release is to be used by all program participants, including Free Rein Horsemanship Program participants. Please complete the information below and have it reviewed by your Physician. All forms must have required signatures and be returned to Free Rein prior to participating.

Participant's Name: _____ Birth Date: _____

Primary Diagnosis: _____ ICD Code: _____

ONSET *(please check one)*: **[ ]**Birth **[ ]**Childhood **[ ]**Adolescence **[ ]**Adulthood

Secondary Dx: _____ Tertiary Dx: _____

Height: _____ inches Weight: _____ lbs. Tetanus Shot: [ ]Yes [ ]No Date of most recent: _____

Please describe any **special precautions** needed **including surgical devices and implants**:

_____

_____

_____ _____

Signature of Parent or Guardian (REQUIRED) Date

Or

_____ _____

Signature of Adult Participant (age 18 or older) (REQUIRED) Date

Participant Medical History

Participant's name: _____ **Date of Birth**_____

Please indicate if the participant has or has had a history of the following by checking yes or no. **If yes, please describe**

Concern	**Yes**	**No**	**History/Describe**
Allergies			
Auditory Impairment			
Cardiac			
Circulatory			
Hemophilia			
Postural Hypertension			
PVD			
Cranial Defects			
Fractures			
Down Syndrome			**Please see note below**
Joint Disease			
Kyphosis/Lordosis			
Degree/Type			
Learning Disability			
Mental Impairment			
Muscular Contracture			
Neurological			
Hydrocephalus			
Pain			
Seizures			Type:
Controlled			
Last Seizure: ____/____/____			
Shunt			
Ossification			
Osteoporosis			
Post-Traumatic Stress Disorder			
Psychological Impairment			

Pulmonary			
Asthma/COPD			
Skeletal			
Dislocating Joints			
Laminectomy/Fusion			
Scoliosis (Degree and Type)			
Brace/ Last X-rRy			
Spinal Column Injury			
Subluxing joints			
Surgical Implants			
Speech Impairments			
Spondylolisthesis			
Visual Impairment			
Other:			
Mobility			
Independent Ambulation			
Cane/Crutches/Walker			
Prosthetics			
Orthotics			
Manual Wheelchair			
Power Wheelchair			
Other:			

Riders with Down Syndrome - PLEASE NOTE:

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

a) Most recent cervical x-ray for AAI: [ ] Positive [ ] Negative……Date of X-ray _____

b) Annual cervical exam for AAI : [ ] Positive [ ] Negative……Date of Exam _____

Physician Release

To be completed by participant's physician

Physician, please note -- The conditions noted on the accompanying medical history, if present, may represent precautions or contraindications to equine assisted activities. Therefore, when reviewing the medical history, please note whether these conditions are present and to what degree. Please be as specific as possible so that we may best serve the rider's needs. **Free Rein will make the final determination about an individual's ability to participate in the program.**

I have reviewed the attached medical history and release **(participant's name)** _____ to participate in appropriate programming at Free Rein. I am aware and permit my patient to actively participate in the following areas (please check all that apply):

sitting astride a horse YES_____ NO_____

grooming horses YES_____ NO_____

other equine related ground activities. YES_____ NO _____

Patient Diagnosis(es): _____

_____

Specific limitations not noted on the medical history: _____

_____

Given the above diagnosis and medical information, I affirm that this person is not medically precluded from participating in supervised equine-assisted activities. I understand Free Rein Horsemanship Program instructors will weigh all medical information against any precautions and contraindications. Therefore, I refer this person to Free Rein Horsemanship Program for ongoing evaluation to determine further eligibility for participating in supervised equine-assisted activities.

Patient's Name: _____

Physician Name: _____MD, DO, NP, PA, Other_____

License/UPIN #_____

Address: _____City: _____ State: ___ Zip: _____

Office Phone: _____ Office Fax: _____

Physician's Signature: _____ Date:_____

When completed with ALL SIGNATURES, please return The Medical History and Physician Release to:

Free Rein Therapeutic Riding and Horsemanship Program
PO Box 30893
Spokane, WA 99223
509-979-1468