Participant Medical History and Physician Consent Form

Name: ____________________________________ DOB: ____________ Height: ________ Weight:______

Address: ____

Diagnosis: ____ Date of Onset: ______________

These conditions may suggest precautions and contraindications to equine activities.

Does the Participant…..	YES	NO	Comments
Have a history of seizures? Type? Controlled?			Date of last seizure:
Follow simple directions?			
Have speech or language difficulties?			
Have communication difficulties?			
Walk independently?			
Have limited range of motion?			
Have decreased strength/endurance?			
Have poor balance (sitting/standing)?			
Have problems with gross motor skills?			
Have problems with fine motor skills?			
Have altered sensation? (specify)			
Have heart/circulation problems?			
Have bone/joint problems?			
Have allergies or breathing problems?			
Have emotional/behavioral problems?			
Have digestion/elimination problems?			
Have a fear of animals/horses?			

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior?
Yes or **No** If Yes, please explain: ______________________________
____
____

Medical History: ______________________________
____

Surgical Procedures (Past and/or future): ______________________________
____

Medications: ______________________________
____

IF DIAGNOSIS IS DOWN SYNDROME, PARTICIPANT MUST HAVE:

1) Yearly Neurologic Evaluation for Symptoms of Atlantoaxial Instability.
2) A signed and dated statement from acting surgeon giving the date and result of procedure.

Courage may require further information to ensure mounted activities are in the best interest of the client.

IF PARTICIPANT HAS HAD A SPINAL INJURY OR INJURY TO ANY BONES THAT REQUIRED SURGERY; PARTICIPANT MUST HAVE:

1) A signed and dated statement from a qualified physician giving the date and result of an X-Ray dated within 3 years.

I UNDERSTAND THAT COURAGE TRC, INC WILL USE THIS INFORMATION TO EVALUATE THIS INDIVIDUAL'S ELIGIBILITY TO PARTICIPATE IN EQUINE-ASSISTED ACTIVITIES.

IN MY OPINION THE PATIENT NAMED ABOVE IS NOT MEDICALLY PRECLUDED FROM PARTICIPATION IN EQUINE-ASSISTED ACTIVITIES AND/OR THERAPIES UNDER APPROPRIATE SUPERVISION.

Physician signature: ______________________________ Date: ______________

Physician's printed name: ______________________________

Address: ______________________________ City: ______________ Zip: __________

Phone: ______________________________ Fax: ______________________________

For questions please contact
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