RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

JNH-S/4

Name _____ Date of Birth _____/_____/_____

Address _____

Name of Parent/Legal Guardian_____

Diagnosis _____Date of Onset _____/_____/____

***For Persons with Down Syndrome:*

Cervical X-ray for Atlantoaxial Instability: □ Positive □ Negative X-Ray Date _____/_____/_____

Tetanus Shot □ Yes □ No Shot Date _____/_____/_____ Height _____ Weight _____

Seizure Type _____ Controlled □ Yes □ No If no, how often_____ Date of last seizure ___/___/___

Medications _____

This individual demonstrates a need for assistance in two (2) or more of these areas: [ ] Capacity for Living Independently
[ ] Receptive & Expressive Language [ ] Learning [ ] Self Care [ ] receptive & Expressive Language [ ] Self Direction or Economic Self Sufficiency

Please indicate current or past difficulties in the following systems/areas, including surgeries:

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Immunity			
Skin & Soft Tissue (Pressure Sores)			
Allergies			
Learning Disability			
Cognitive			
Mental Impairment			
Psychological Impairment			
Past Surgeries			
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 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, Speech, Psychologist, etc) in the implementing of an effective equestrian program.

Physician Name (please print) _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Date _____

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To: Physicians, Therapists, Referring Agencies, & Parents/Legal Guardians:

PLEASE BE ADVISED OF THE FOLLOWING CONDITIONS IN WHICH THERAPEUTIC RIDING MAY BE CONTRAINDICATED

DIRECT CONTRAINDICATIONS

ORTHOPEDIC:
Acute herniated disc
Coxa arthrosis (degeneration of the hip)
Spondylotisthesis
Pathological fractures (e.g. osteogenesis imperfecta)
Spinal fusion, organic or operative (e.g. Harrington rods)
Structural scoliosis greater than 25-30 degrees or excessive Kyphosis or lordosis: hemivertibrae
Unstable spine including subluxation of the cervical spine
Hip Subluxation

MEDICAL
Acute stage of arthritis
Atlanto-axial instability:
All patients with Downs Syndrome are required to provide side view cervical X-rays including full flexion and full extension views and a statement from a physician stating that a physical examination did not reveal atlanto-axial instability or focal neurological disorder.
Anti-coagulant medication
Exacerbation of multiple sclerosis
Hemophilia
Open pressure sores/wounds on contact surfaces
Steoporosis (severe)
Uncontrolled seizures
Drug dosages causing physical states inappropriate in a riding environment
CVA – secondary to unclipped aneurysm, or presence of other aneurysms – secondary to angioma that was not totally resected
Tethered Cord or Chiari II Malformation Associated with Spina Bifida Cystica

RELEASE AND INDEMNITY AGREEMENT

We, the parent(s)/legal guardian/I acknowledge that we/I understand the medical authorization of Dr. _____ does not constitute any assurance that I will receive physical or psychological benefits from the program conducted by Jamestown New Horizons, or does it constitute an assessment of the risk of possible injury to me/my child in relation to the possible physical or psychological benefits from participating in the program.

In consideration of the services and the medical authorization of Dr. _____ I hereby waive, release, and relinquish and and all claims against him/her for any and all liability arising from his/her authorization for me to participate in the program offered by Jamestown New Horizons, and I hereby agree to hold harmless and to indemnify said physician against any and all claims arising from said authorization.

Under Missouri Law an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the revised statutes of Missouri.

Date _____ Signature of participant if 18 yrs of age or older _____

Signature _____ Signature _____

Print Names of Signatures _____ Relationship to participant _____

* Both parents of child under 18 years of age must sign unless you have sole legal custody or are the sole living parent or legal guardian.

OVER ►

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MFH Missouri Foundation for Health
PLB Productive Living Board for St. Louis County Citizens with Developmental Disabilities
Partially funded by the Productive Living Board
"Gone Riding"®