

THROWAWAY PONIES THERAPEUTIC RIDING
Medical History & Physician's Statement

Participant _____ DOB _____ Height _____ Weight _____

Address: _____

Diagnosis _____ Date of Onset _____

Past/Prospective Surgeries _____

Medications: _____

Allergies: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Behavioral			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Name/Title _____ Address _____

City _____ Zip _____ Telephone _____

Signature _____ Date _____

Must be signed by licensed physician, PA or Nurse Practitioner.

