



Good Hope Equestrian Training Center Equine Activity Application & Medical History

Participant's name: _____

(Physician must complete this portion of the application)

Please check the following conditions that apply to your patient:

Orthopedic

Spinal Fusion _____

Spinal Instability/Abnormalities _____

Atlantoaxial Instability _____

Scoliosis _____

Kyphosis _____

Lordosis _____

Hip Subluxation and Dislocation _____

Osteoporosis _____

Pathological Fracture _____

Coxa Arthrosis _____

Heterotopic Ossification _____

Osteogenesis Imperfecta _____

Cranial Deficits _____

Spinal Orthoses _____

Internal Spinal Stabilization Devices _____

Neurological

Hydrocephalus/Shunt _____

Spina Bifida _____

Tethered Cord _____

Chiari II Malformation _____

Hydromyelia _____

Seizure Disorders _____

Autistic Spectrum Disorder _____

Medical/Surgical

Allergies _____

Cancer _____

Diabetes _____

Peripheral Vascular Disease _____

Varicose Veins _____

Hemophilia _____

Hypertension _____

Serious Heart Conditions _____

Stroke (Cerebrovascular Accident) _____

Other Disorders & Conditions

Multiple Sclerosis _____

Arthritis _____

Aggressive Behavior _____

Indwelling Catheters _____

Skin Breakdown _____

Respiratory Conditions _____

Cardiac Conditions _____

Medication Side Effects _____

Other _____

If your patient has any of the following conditions, describe them in detail. In addition, do you believe your patient's condition could worsen if he/she participates in equine related activities? (Horseback riding, hippotherapy and/or horsemanship activities, such as grooming, bathing, tacking and leading)

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Good Hope Equestrian Training Center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of the participant's abilities/limitations by licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ MD DO NP PA

Physician's Signature: _____

Date: _____

Address: _____

Phone: (____) _____