Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____
For those with Down Syndrome: Neurological exam for Atlanto Axial Instability, date: _____ Result: + -
Neurologic Symptoms of Atlanto Axial Instability: _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

| Student is typically developing and there are no known conditions to exclude him/her from equine assisted activities.

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities or therapies. I understand that Paramount ARC will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Paramount ARC for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____
Signature: _____ Date: _____
Address: _____
Phone: ( )_____ License/ UPIN Number: _____