## Participant's Medical History & Physician's Statement

| Address: Diagnosis: Diagnosis: Diagnosis: Diagnosis: Dest/Prospective Surgeries: Medications: Secizure Type: 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: Pease indicate current or past special needs in the following systems/areas, including surgeries:  Y N Comments  Auditory Visual Visua | Participant:  |                    | DOB: | Height:              | Weight:      |  |
|--|---|--------------------|------|----------------------|--------------|--|
| Diagnosis:   | Address:  |                    |      |                      |              |  |
| Past/Prospective Surgeries:  Medications:  Seizure Type:   |   |                    |      |                      |              |  |
| Medications:   | Past/Prospective Surgeries:   |                    |      |                      |              |  |
| Seizure Type:  |   |                    |      |                      |              |  |
| Shunt Present: Y N Date of last revision:  |   |                    |      | olled: Y N Date of L | ast Seizure: |  |
| 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:  |   |                    |      |                      |              |  |
| Braces/Assistive Devices: For those with Down Syndrome: Neurological exam for Atlanto Axial Instability, date:   | •   |                    |      |                      |              |  |
| Braces/Assistive Devices: For those with Down Syndrome: Neurological exam for Atlanto Axial Instability, date:   | Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N   |                    |      |                      |              |  |
| For those with Down Syndrome: Neurological exam for Atlanto Axial Instability, date:   |   |                    |      |                      |              |  |
| Neurologic Symptoms of Atlanto Axial Instability:    Please Indicate current or past special needs in the following systems/areas, including surgeries:    Y   |   |                    |      |                      |              |  |
| Please indicate current or past special needs in the following surgeries:    Y   N   Comments  |   |                    |      |                      |              |  |
| Auditory Visual 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 determine eligibility for participation.  Name/Title:  |   |                    |      |                      |              |  |
| 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:   |   | 1                  |      |                      |              |  |
| 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:  | Auditory  |                    |      |                      |              |  |
| 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:   |   |                    |      |                      |              |  |
| 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 to determine eligibility for participation.  Name/Title:  Signature:  Date:  Address:  |   |                    |      |                      |              |  |
| 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 to determine eligibility for participation.  Name/Title:  Signature:  Date:  Address:  | Speech  |                    |      |                      |              |  |
| 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:  | ,   |                    |      |                      |              |  |
| 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:   | Circulatory   |                    |      |                      |              |  |
| 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:  | Integumentary/Skin  |                    |      |                      |              |  |
| 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:   | Immunity  |                    |      |                      |              |  |
| 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:  | Pulmonary   |                    |      |                      |              |  |
| 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:  | Neurologic  |                    |      |                      |              |  |
| 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:   | Muscular  |                    |      |                      |              |  |
| 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:   | Balance   |                    |      |                      |              |  |
| 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:  | Orthopedic  |                    |      |                      |              |  |
| 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:  | Allergies   |                    |      |                      |              |  |
| 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:   | Learning Disability   |                    |      |                      |              |  |
| 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: Date: Address: Date: Address: Date: Address: Date: Address: Date: Address: Date: Address: Date: Date: Address: Date: Date: Date: Date: Date: Date: Date: Date:   |   |                    |      |                      |              |  |
| 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: Date: Address: Date: Address: Date: Address: Date: Date: Address: Date:   | Emotional/Psychological   |                    |      |                      |              |  |
| 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: Date: Date: Address: Date: Date: Date: Address: Date:  |   |                    |      |                      |              |  |
| 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:  | Other   |                    |      |                      |              |  |
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| 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: Date: Address: Date: Address: Address MRC for ongoing evaluation to determine eligibility for participation.  |   |                    |      |                      |              |  |
| Name/Title:  |   |                    |      |                      |              |  |
| Name/Title: MD DO NP PA Other:<br>Signature: Date:<br>Address:   |   |                    |      |                      |              |  |
| Signature: Date:<br>Address:   | determine eligibility for participation.  |                    |      |                      |              |  |
| Address:   | Name/Title:   | MD DO NP PA Other: |      |                      |              |  |
|  |   |                    |      |                      |              |  |
|  |   |                    |      |                      |              |  |
|  |   |                    |      |                      | Number:      |  |