# SOLID GROUND

EQUINE ASSISTED ACTIVITIES AND THERAPY CENTER

Date:_____

Dear Health Care Provider:

Your patient,_____, is interested in participating in equine assisted activities and therapy.

In order to safely provide this service, our therapeutic riding center, **Solid Ground Equine Assisted Activities and Therapy Center**, requests that you complete the attached **Medical History and Clearance Form**. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**ORTHOPEDIC**

Atlantoaxial Instability – include neurological symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures Spinal
Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

**MEDICAL/PSYCHOLOGICAL**

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Setting
Hemophilia Medical
Instability Migraines
PVD
Respiratory Compromise
Recent Surgeries Substance
Abuse Thought Control
Disorders Weight Control
Disorder

**NEUROLOGIC**

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II
Malformation/Tethered
Cord/Hydromyelia

**OTHER**

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Solid Ground Equine Therapy Center at the email or phone indicated below.

Sincerely,

*Shelley Trumbly, RN Executive Director*
*strumbly@solidgroundkf.org*
*(541)539-6303*

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## MEDICAL HISTORY AND CLEARANCE

Name_____ DOB_____ Gender: _____

Height_____ Weight_____ Pulse_____ BP_____

Diagnosis _____

Seizure Type *(if any)*_____ Controlled? Y or N Date of last seizure_____

Tetanus Shot Y or N Date_____

**Persons with Down Syndrome:** This section must be completed each year. The neurologic signs of AAI (Atlantoaxial Instability) is a contraindication for mounted equine activities. After a neurological exam, this patient shows:

**NO sign of AAI (Atlantoaxial Instability)**_____**YES Shows sign(s) of AAI** _____

**Physician Signature**_____**Date** _____

**Please indicate if the client has, or had a history of, the following secondary problems, by checking yes or no. If Yes, please include COMPLETE information pertaining to the problem.**

| PROBLEM | Yes | No | IF YES, DESCRIBE |
|---|---|---|---|
| Auditory Impairment | | | |
| Visual Impairment | | | Glasses? |
| Speech Impairment | | | |
| Tactile Sensation | | | |
| Learning Disability | | | |
| Cognitive Impairment | | | |
| Psychological Impairment | | | |
| Cardiac | | | |
| Pulmonary/COPD/Other | | | |
| Neurological | | | |
| Muscular | | | |
| Orthopedic (Skeletal)/ Scoliosis Degree | | | |
| Balance | | | |
| Allergies (Please Include Medications) | | | |
| Asthma | | | |
| Shunts | | | |
| Postural Hypertension | | | |
| Hemophilia | | | |
| Orthotics | | | |
| Other | | | |

**MOBILITY**

Independent Ambulation: Yes or No  Crutches Yes or No  Braces Yes or No  Wheelchair Yes or No

**Please indicate any special precautions**

_____
_____
_____
_____
_____
_____

*In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical, occupational, or other behavioral health professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.*

*I, a Licensed Medical Physician, have evaluated and medically cleared the following individual.*

Client Name: _____  Date:_____

_____  _____
*Physician's Signature*  *Physician's Name (Print)*

_____  _____
*Clinic Name*  *Phone*