

Date: _____

Dear Health Care Provider:

Your patient, _____ [Child's name] is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement 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
 Coxarthrosis
 Cranial Defects
 Heterotopic Ossification/Myositis Ossificans
 Joint subluxation/dislocation
 Osteoporosis
 Pathologic Fractures
 Spinal Joint Fusion/Fixation
 Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
 Seizure
 Spina Bifida/Chiari II Malformation

Other

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

Medical/Psychological

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

Precautions and Contraindications

The primary focus of any facility offering equine related services is to provide a safe and productive experience for all participants. Mitey Riders abides by precautions and contraindications as defined by the Professional Organization of Therapeutic Horsemanship International and precautions and contraindications as prescribed by a potential participant's physician.

Please consider the following when deciding to include therapeutic horseback riding for your client:

- 1) **Movement:** Most equine related services inherently involve movement. If this movement will cause a decrease in the participant's function, and increase of pain, or generally aggravate the medical condition it may not be the intervention of choice.
- 2) **Fall Risk:** Equine related services always present the potential for a fall. Such a fall may cause a greater functional impairment than the participant originally had. The possibility of a fall should be given careful consideration when making this informed decision.
- 3) **Atlantoaxial Instability & Down Syndrome**
There are inherent risks involved with equine related services for individuals diagnosed with Down syndrome and/or atlantoaxial instability. Atlantoaxial instability increases the possibility of injury in an activity that hyper-extends, radically flexes, or creates direct pressure on the neck or upper spine. A fall from a horse, a sudden movement of the horse, or even the horse's normal stride/movement can create hyper-extension or hyper-flexion of the neck and upper spine.

As a result, Mitey Riders, following the guidelines of PATH International, considers any evidence, radiological or by presence of neurologic symptom, a contraindication for therapeutic horseback riding. Accordingly, **neurologic signs always supersede radiographs as a contraindication.**

PATH international requires that all potential participants with Down syndrome have a medical examination by a licensed physician including a complete neurological exam annually that shows **no evidence of AAI or neurologic symptoms.**

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please contact the center at the address/phone indicated above.

Sincerely,
Misty Meadows Mitey Riders

**PHYSICIAN
FORMS**

Physician's Statement & Medical History

This section MUST be filled out by your child's general physician.

Rider Name (First/Middle/Last): _____

DOB: ____ / ____ / ____ Age: ____ Height: ____ Weight: ____ lbs.

Diagnosis: _____

Date of Onset: _____ Date of last Tetanus Shot: _____

Medications: _____

Seizure Type: _____ Controlled: Y / N

Date of Last Seizure: _____

Shunt Present: Y / N Date of last revision: _____

Mobility: Independent Ambulation Y / N Assisted Ambulation Y / N

Wheelchair Y / N

Braces/Assistive Devices: _____

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

AREA	Yes	No	Comments
Auditory			
Visual			
Speech			
Tactile Sensation			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Neurological			
Immunity			
Muscular			
Orthopedic			
Allergies			
Emotional/Mental Health			
Pain			
Behavioral			
Bone/Joint			
Learning Disability			
Current on NC and physician recommended vaccinations			
Other:			

PHYSICIAN
FORMS

Rider Name (First/Middle/Last): _____

This section MUST be filled out by your child's general physician.

This person is not medically precluded from participation in equine-assisted activities. I understand that Misty Meadows Mitey Riders will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Misty Meadows Mitey Riders for ongoing evaluation to determine eligibility for participation.

Note- All riders wear helmets during mounted and unmounted activities.

Precautions: _____

Note: All riders wear helmets

Physician Name Printed: _____

Physician Signature: _____

Date _____

Address: _____

Phone: _____

License/UPIN Number: _____

For patients with Down syndrome:

Therapeutic horseback riding **is contraindicated** by the Professional Association of Therapeutic Horsemanship International if any of the following conditions are present:

- neurologic symptoms of atlantoaxial instability (AAI) **OR**
- positive neurologic clinical signs as evaluated by a physician, **OR**
- significant AAI measurement as determined by a physician, or excessive head/neck instability with or without a helmet.

Physicians: Please verify that this patient has no evidence of AAI and no decrease in neurologic function:

AtlantoDens Interval X-rays, date: _____

Result: + / -

Are neurologic symptoms of Atlantoaxial Instability present?
