CTRH Participant's Medical History & Physician's Statement 2024

THIS FORM MUST BE COMPLETED ANNUALLY TO BE CONSIDERED FOR PARTICIPATION

Participant Information (to be filled out by Participant/Parent/Caregiver)

Applicant's Name:			Nickname:	:		
Age: (minimum age: 2 1/2 - HPOT; 5 - Recre			eational Riding)	Birthdate:	Gender:	
Address: Street						
Street			City	State	Zip	
Parent/Guardian/Caregiver Na	ame(s):			Phon	e:	
Emergency Contact:				Phon	e:	
Primary Physician:					,	
	Participa	nt Medical In	formation (to be filled	out by Physician	1)	
iagnosis:			Complete both sections for participants with Down syndrome:			
Weight:lbs. (175 lbs		•	Neurologic symptom	ns of Atlantoaxial	Instability	
Height: (150 lbs		•	Exam date	enegativ	ve positive	
Tetanus Shot: No Y		· · · · · · · · · · · · · · · · · · ·	!!Neurologic exam	must be complete	d every calendar year!!	
Normal Blood Pressure:			Cervical X-Ray for Atlanto	axial Instability	_ X-ray date:	
Normal Temperature:	_		negative	positi	ve	
Medications:						
Past medical history, proble						
	Yes	No	Comments			
Auditory						
Visual						
Speech						
Cardiac						
Circulatory						
Pulmonary						
Neurological						
Muscular						
Orthopedic						
Allergies						
Learning Disability						
Mental Impairment						
Psychological Impairment						
Seizure Disorder						
Controlled			Date of last seizure: _			
Mobility Status						
Independent	Walker	Ca	ane Cr	utches	_ Wheelchair	
Transfer Ability:						

Information for Physician

Neurologic

The following conditions, if present, may represent precautions or contraindications to hippotherapy and/or therapeutic riding. Please indicate whether these conditions are present and to what degree.

Medical/Surgical

Orthopedic

Spinal Fusion Allergies Hydrocephalus / Shunt Spinal Instabilities / Abnormalities Cancer Spina Bifida Scoliosis Poor Endurance **Tethered Cord Kyphosis** Recent Surgery Chiari II Malformation Lordosis Diabetes Hydromyelia Peripheral Vascular Disease Paralysis due to Spinal Cord Injury Hip Subluxation / Dislocation Osteoporosis Varicose Veins Seizure Disorders Pathologic Fractures Hemophilia Cardiac Condition Coxas Arthrosis **Secondary Concerns** Stroke Heterotopic Ossification **Behavior Problem** Acute Exacerbation of Chronic Disorder Osteogenesis Imperfecta Cranial Deficits Indwelling Catheter **Spinal Orthoses** Internal Spinal Stabilization Devices Atlantoaxial Instability - include neurologic symptoms ** PHYSICIANS PLEASE TAKE NOTE: If approving for Hippotherapy, a signature is REQUIRED in BOTH boxes below. **

Physician's Statement for All Participants:					
To my knowledge there is no reason why this	person cannot participate in supervi	sed equestrian activitie	s. I understand		
that the PATH center will weigh the medical in	formation given against the existing	precautions and contra	aindications.		
Therefore, I refer this person to the PATH cent	ter for ongoing evaluation to determ	ine eligibility for particip	oation.		
Physician's Name (Please Print):	Phone:				
Physician's Signature:		Date:			
Address:					
Street	City	State	Zip		
Prescription for Hippotherapy Participants	Only:				
Prescription for occupational, speech therapy,	and physical therapy utilizing hippo	therapy as a therapeuti	c strategy.		
Functional goals will integrate improvement wi	th balance, strength, posture, comm	nunication, and activitie	s of daily living.		
Physician's Signature:	Physician's Na	Physician's Name:			

Phone: 513-831-7050, Secure Fax: 844-716-2708 info@ctrhohio.org

^{*} Hippotherapy Balanced Rider has fair sitting balance and does not need upper extremity support or external support to maintain posture when the horse is moving. This is subject to therapist/instructor's discretion.

^{*} Recreational Riding Balanced Rider shows flexibility, strength, posture and the ability to change their weight distribution on the horse as needed. This is subject to therapist/instructor's discretion.