Storm Harbor Equestrian Center
245 Harmony Rd
Slippery Rock, PA 16057
724-738-4015

Participant Medical History & Statement

Name: _____ DOB: _____ Height: _____ Weight: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizures ☐ Yes ☐ No Type: _____ Last Seizure Date: _____
Shunt Present ☐ Yes ☐ No Date of Last Revision: _____
Special Precautions/Needs: _____
_____
Mobility (Check One): ☐ Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair
Braces/Assistive Devices: _____
**For those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability:* ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____
Address: _____
Phone: (___)_____ License/UPIN Number: _____

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Date: _____
Dear Health Care Provider:
Your patient: _____
(participant's name)

Is interested in participating in supervised equine activities.
In order to safely provide this service, our center requests that you complete/update 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- include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurological
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

Medical
Allergies
Animal Abuse
Blood Pressure Control
Cardiac Conditions
Physical/sexual/Emotional Abuse
Dangerous to self or others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire setting
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries
Recent Abuse
Thought Control Disorders
Weight Control Disorder

Psychological
Substance Abuse
Thought Control Disorders
Weight Control Disorders
Animal Abuse
Physically Abusive
Sexually Abusive
Emotionally Abusive
Fire Setting

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

Sincerely,
Storm Harbor Equestrian Center
Slippery Rock University