Physician's Statement

This form must be completed and signed by a health care professional and updated annually:
The following conditions, if present, may represent **precautions or contraindications** to therapeutic horseback riding. Therefore, please note if any of these conditions are present, and to what degree.
Please be as specific as possible so that we may best serve the participant's needs.
(Circle conditions that are present and add specifics below.)

Participant:_____

Date of birth_____ **Height**_____ **Weight**_____

Primary diagnosis:_____

Orthopedic	**Medical**	**Neurologic**
Spinal Fusion	Allergies	Hydrocephalus/shut
Spinal Instabilities/Abnormalities	Cancer	Tethered Cord
Atlantoaxial instabilities	Poor endurance	Chiari ll Malformation
Scoliosis (>30, riding is contraindicated)	Recent surgery	Hydromyelia
Kyphosis	Diabetes	Paralysis due to spinal cord injury
Lordosis	Peripheral Vascular Disease	Seizure Disorders
Hip Subluxation and Dislocation	Varicose Veins	
Osteoporosis	Hemophilia	

Secondary Concerns		
Pathologic Fractures	Hypertension	Behavior Problems
Coxas Arthrosis	Serious Heart Condition	Age under two years
Heterotopic Ossification	Stroke (Cerebrovascular Accident	Age two – four years
Osteogenesis Imperfecta		Acute exacerbation of chronic disorder
Cranial Deficits		Indwelling catheter
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Other Condition(s) not listed above: _____

Please indicate specifics related to any existing health conditions, including degree of conditions such as scoliosis and osteoporosis, type of behavior problems, recent surgeries, type of seizures etc:

_____

_____

_____

For participants with Down Syndrome

Please note:
Due to the nature of equine activities, including horseback riding, participants with Down syndrome must have an annual medical clearance from a licensed physician that includes a neurologic exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI).

Please provide the following information:

a) Annual neurologic exam for AAl: [ ]Negative … Date of Exam _____

Does the participant have a health concern or surgeries in any of the following areas? If yes, please explain:

Auditory_____

Visual _____

Speech _____

Cardiac _____

Circulatory _____

Pulmonary _____

Neurological _____

Muscular _____

Orthopedic _____

Allergies _____

Learning Disabilities _____

Mental or Psychological Impairment _____

Other: _____

Please describe any concerns or special medical or physical precautions or adaptations needed:

_____

_____

_____

_____

_____

HEALTH CARE PROVIDER'S STATEMENT

(Signature Required)

To the best of my knowledge, there is no reason why this person cannot participate in supervised equestrian activities, including horseback riding. However, I understand that the staff at Midnight Farm will consider the medical information I have provided to determine their ability to meet the individual's existing health conditions, precautions and requirements.

Health Care Provider_____Title_____

Office Address: _____Phone:( )_____

REQUIRED:

Health Care Provider Signature _____ Date: _____

EMERGENCY MEDICAL TREATMENT

(This form must be updated annually)

Name: _____DOB:_____

Participant's Diagnosis: _____

Describe any medical conditions requiring special consideration, including allergies or seizures, and current medications and dosage:

_____

_____

Physician's Name: _____Phone: _____

PREFERRED Medical Facility: _____

Emergency Contact Information:

Name: _____Relationship:_____

Preferred Phone:(___)_____Alternate Phone: (____)_____

The following person has <u>temporary authorization</u> to make medical decisions if Primary Emergency Contact cannot be reached:

Name: _____Relationship:_____

Preferred Phone:(___)_____Alternate Phone: (____)_____

In case of medical emergency, the undersigned authorizes Midnight Farm to provide such medical assistance as they determine to be necessary, including the release of above named person's records. If the person named above is under 18 years of age, the undersigned authorizes Midnight Farm, acting through the adult on its staff who has actual care, control and possession of the person to consent to medical, dental, and surgical treatment of the person when the above named emergency contacts cannot be reached. The undersigned represents to Midnight Farm that he or she is over 18 years of age or parent/legal guardian and either is not divorced from the other parent, or is divorced from the other parent, but has been authorized by a written court order to give consent to medical and dental care and surgical treatment of the above name person. The undersigned will indemnify and hold Midnight Farm, its officers, members, employees and agents harmless if he or she is not empowered by law to give this consent.

The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the above named person, including anesthesia, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

Please choose <u>ONLY ONE</u> of the following options, do not sign both:

_____**<u>I CONSENT</u>** to the above stated emergency medical procedures:

_____Date:_____
Signature of Adult Participant or Parent/Guardian if under 18 or has a guardian

_____ _____
Insurance Carrier Policy Number

_____**<u>I DO NOT CONSENT</u>** to above emergency medical procedures and would like the following procedures to take place in the event of a medical emergency:

_____

_____

_____Date:_____
Signature of Adult Participant or Parent/Guardian if under 18 or has a guardian