Aeroflex Equine Therapy

Medical Information & Release

PARENT/GUARDIAN:	
PHONE NUMBER:	

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

Medical	Yes	No	Comments
Appearance/ Affect	☐	☐	
Eyes/Ears/Nose/Throat	☐	☐	
Lymph Nodes	☐	☐	
Pulses	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Skin	☐	☐	
Neurologic	☐	☐	
MUSCULOSKELETAL	☐	☐	
Neck	☐	☐	
Back	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	

FOR PERSONS WITH DOWN SYNDROME				
Does this patient have symptoms consistent with atlantoaxial instability?	☐	☐	Date of Exam:	

Physicians Release: (only if under a physician's care)
I have examined the above-named participant and given the participants diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Tri-County Behavioral Care will weigh the medical information provided against the existing precaution and contraindications; therefore, I refer this person to the Tri-County Behavioral Care got ongoing evaluation to determine eligibility for participation.

Physician's Signature:				Date:	
Physician's Name: (Please Print)				Phone Number:	
Address:		City/State:		Zip:	

Physician's Release

Dear Physician:

Your patient would like to participate in one of our Equine Assisted Activities and Learning programs at Tri-County Behavioral Care (Program may include riding). These activities are supervised by riding and/or groundwork instructors who are certified by the Professional Association for Therapeutic Horsemanship International (PATH Intl.) and assisted by trained volunteers. Because safety is of the utmost importance, we request your evaluation of this person's appropriateness for groundwork and/or horseback riding at Tri-County Behavioral Care.

The following are some of the precautions/contraindications that we take into account when considering riders for our programs. We welcome your comments, questions, and concerns. All of our participants must have an original signed and dated Physician's Release on file with Tri-County Behavioral Care in order to participate.

Orthopedic	**Medical/ Psychological**
Atlantoaxial instability	Allergies
Coxa Arthrosis	Animal abuse
Cranial Deficits	Poor Endurance
Scoliosis	Blood pressure control
Heterotopic Ossification	Dangerous to self or others
Myositis Ossificans	Exacerbation of medical conditions
Joint subluxation/ dislocation	Fire setting
Osteoporosis	Heart conditions
Pathologic fractures	Hemophilia
Spinal fusion/fixation	Medical instability
Spinal instability/ abnormalities	Migraines
	PVD
Neurologic	Hypertension
Hydrocephalus/ shunt	Recent Surgeries
Seizure Disorders	Substance abuse
Spina bifida	Thought control disorder
Hydromyelia	Weight control disorder

Medical History & Physician's Statement

Diagnosis:_____ Date of Onset:_____

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

	Yes	No	Comments
Vision	☐	☐	
Hearing	☐	☐	
Communication/ Speech	☐	☐	
Sensation	☐	☐	
Immune Deficiency	☐	☐	
Circulation	☐	☐	
Digestion	☐	☐	
Cognitive Development	☐	☐	
Fatigue/Limited Endurance	☐	☐	
Muscular	☐	☐	
Orthopedic (spine/joints)	☐	☐	
Emotional/ Psychological	☐	☐	
Behavior	☐	☐	
Pain	☐	☐	
Other	☐	☐	

Does the participant have or use:

Asthma:	☐**Yes**	☐**No**			Walker:	☐**Yes**	☐**No**
Epipen:	☐**Yes**	☐**No**			Crutches:	☐**Yes**	☐**No**
Inhaler:	☐**Yes**	☐**No**			Wheelchair:	☐**Yes**	☐**No**

I hereby affirm that, to the best of my knowledge the health history information is complete and correct.

Name of Person Completing this form:		Date:	
Signature:		Relationship to Participant:	

Tri-County Behavioral Care reserves the right to request additional information and/ or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.