HORSESENSE THERAPUTIC RIDING CENTER

MEDICAL RELEASE FORM

145 Easy Street, Howell, NJ 07731
Phone 732-910-7855

If the rider has any Medical or Physical concerns that we should be aware of – Please list:

Diagnosis:____
Medications:____
Seizure Type:__________________________ Controlled: Yes or No Date of last seizure:_______________
Special Precaution/Needs:
____
____
Mobility: Independent Ambulation: Y / N Assisted Ambulation: Y / N Wheelchair: Y / N
Braces/Assisted Devices:____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____________________Results: + -
Neurologic Symptoms of Atlanto Axial Instability:____

Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that HorseSense LLC will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to HorseSense Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name/Title:____ MD DO NP PA Other
Signature:____ Date:______________
Address:____
Phone:__________________________________