

# CTRH Participant's Medical History & Physician's Statement 2026

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 - Recreational Riding)

Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian/Caregiver Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

## Participant Medical Information (to be filled out by Physician)

Diagnosis: \_\_\_\_\_

**Complete both sections for participants with Down syndrome:**

Weight: \_\_\_\_\_ lbs. (175 lbs. limit balanced rider)\*

**Neurologic symptoms of Atlantoaxial Instability**

Height: \_\_\_\_\_ (150 lbs. limit unbalanced rider)\*

\_\_\_\_\_ Exam date \_\_\_\_\_ negative \_\_\_\_\_ positive

Tetanus Shot: \_\_\_\_\_ No \_\_\_\_\_ Yes - Date: \_\_\_\_\_

*!!Neurologic exam must be completed every calendar year!!*

Normal Blood Pressure: \_\_\_\_\_

Cervical X-Ray for Atlantoaxial Instability \_\_\_\_\_ X-ray date: \_\_\_\_\_

Normal Temperature: \_\_\_\_\_

\_\_\_\_\_ negative \_\_\_\_\_ positive

Medications: \_\_\_\_\_

## Past medical history, problems, and/or surgeries

	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 \_\_\_\_\_ Cane \_\_\_\_\_ Crutches \_\_\_\_\_ Wheelchair

Transfer Ability: \_\_\_\_\_

### Information for Physician

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.**

#### Orthopedic

Spinal Fusion  
Spinal Instabilities / Abnormalities  
Scoliosis  
Kyphosis  
Lordosis  
Hip Subluxation / Dislocation  
Osteoporosis  
Pathologic Fractures  
Coxas Arthrosis  
Heterotopic Ossification  
Osteogenesis Imperfecta  
Cranial Deficits  
Spinal Orthoses  
Internal Spinal Stabilization Devices  
Atlantoaxial Instability - include neurologic symptoms

#### Medical/Surgical

Allergies  
Cancer  
Poor Endurance  
Recent Surgery  
Diabetes  
Peripheral Vascular Disease  
Varicose Veins  
Hemophilia  
Cardiac Condition  
Stroke

#### Neurologic

Hydrocephalus / Shunt  
Spina Bifida  
Tethered Cord  
Chiari II Malformation  
Hydromyelia  
Paralysis due to Spinal Cord Injury  
Seizure Disorders

#### Secondary Concerns

Behavior Problem  
Acute Exacerbation of Chronic Disorder  
Indwelling Catheter

**\*\* 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 supervised equestrian activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

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 hippotherapy as a therapeutic strategy.

Functional goals will integrate improvement with balance, strength, posture, communication, and activities of daily living.

Physician's Signature: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

\* 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.

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