Attach to "Client Medical History & Physicians Statement" and give to Doctor.

JoyRide Center, Inc.
29550 Tudor Way
Magnolia, TX 77355
281-356-5900
Fax 281-356-5901
www.joyridecenter.org

Dear Health Care Provider:

Your patient, _____
(Client's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete 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 Instabilities – including neuralgic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Poor Endurance
Skin Breakdown
Medications – i.e. photosensitivity
Indwelling Catheters

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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the Horsemanship Program Manager at the center at the address/phone indicated below.

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CLIENT MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

To be completed by physician and returned to JoyRide Center

JOYRIDE CENTER, INC.
29550 TUDOR WAY
MAGNOLIA, TX 77355
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Client Name:_____ M/F: _____ Date of Birth: _____

Guardian Name:_____Guardian Phone:_____

Height: _____ Weight: _____ Has client had a bone density test: Y N Score:_____

Diagnosis: _____ Date of Onset: _____

CurrentMedications: _____

Known Allergies:_____Treatment:_____

Past/Prospective Surgeries:_____

Shunt Present: Y N Date of last revision: _____

Seizure Type: _____Controlled: Y N Date of Last Seizure: _____

Mobility: Independent Ambulation: ☐Yes ☐ No Assisted Ambulation: ☐Yes ☐No

Wheelchair: ☐Yes ☐ No Braces/Assistive Devices:_____

***For those with Down Syndrome**: A yearly medical exam including a complete neurologic exam has been done and shows no evidence of Atlantoaxial Instability.* ☐ Yes ☐ No _____Initials

For those with Scoliosis: Please indicate degree and location of curvature_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

AREAS	YES	NO		AREAS	YES	NO		AREAS	YES	NO
Auditory				Skin				Orthopedic		
Visual				Immunity				Allergies/Asthma		
Tactile Sensation				Pulmonary				Learning Disability		
Speech				Neurologic				Cognitive		
Cardiac				Muscular				Psychological		
Circulatory				Balance				Pain		

Please provide additional comments for areas marked "yes" above or list any special precautions/needs:

_____

_____

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 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.

Print Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

Address: _____

Phone: (_____)_____ License/UPIN #: _____

Prescription for Physical or Occupational Therapy

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Magnolia, TX 77355
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Fax 281-356-5901
www.joyridecenter.org

Client: _____ **DOB:** _____

Prescription for evaluation and treatment by a Physical Therapist or Occupational Therapist at the JoyRide Center, Inc.

Recommended frequency: 1X per week

Precautions: Universal, _____

_____

Physician's Signature: _____

Date: _____

Please print or stamp:

Physician's name: _____

Address: _____

_____

Phone: _____

For additional information, we encourage you to contact our therapist:

Emma Lean, PT, HPCS
281-356-5900
ELean@joyridecenter.org