MEDICAL RELEASE PACKET

Date:_____

Dear Healthcare Provider:

Your patient,_____, has been participating in supervised equine activities at Ride for Joy Therapeutic Riding Program, and is due for an update of his/her medical status. In order to safely provide this service, we request that you complete the attached Medical Information and Physician's Statement Form. If this person has Down Syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her most recent neurologic exam (must have been within the last year).

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, if so, to what degree.

Orthopedic

- Atlantoaxial Instability – include neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to Self or Others
- Exacerbations of medical conditions (i.e. RA, MS)
- Fire Setting
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

Neurologic

- Hydrocephalus/Shunt
- Sensory Deficit
- Seizure
- Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

- Age – under 4 years
- Indwelling Catheters/Medical Equipment
- Medications – i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

Thank you very much for your assistance. If you have any questions about therapeutic riding activities, please email the RFJ Program Coordinator at lpekovich@rideforjoy.org.

Sincerely,

Lucy Pekovich
Ride for Joy Program Coordinator

RIDE for JOY

Participant Name: _____

DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

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

Shunt Present: Y N Date of last revision: _____ Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays Date: _____ Result + -

***Were neurologic symptoms of AtlantoAxial Instability present at this visit*? Y N Date: _____**

If yes, symptoms observed were**:** _____

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

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			

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	Y	N	Comments
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is <u>not</u> medically precluded from participating in equine assisted activities. I understand that Ride for Joy will weigh the medical information provided against the existing precautions and contraindications. Therefore, I refer this person to Ride for Joy for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other _____

Signature:_____ Date: _____

Address: _____

Phone:_____ License/UPIN Number: _____

PLEASE FAX THIS FORM TO:
1-208-550-3208