O.A. T.S.hrh

P. O. Box 138

Clarkston, MI 48347

248-620-1775 phone / 866-575-6777 fax

www.oatshrh.org - WalkOnOats@gmail.com

Medical History and Physician's Release Form – Must be filled out by a Physician

Name:		Birth date:	
Street Address:		Ht:	Wt:
City/State/Zip:			
Name of ☐ Parent or ☐ Guardian			
Address, if different from above:			
Primary Diagnosis:		Date of Onset:	
Seondary Diagnosis:		Date of Onset:	
Seizuree Type:	Controlled?	Date of last Seizure:	

AREAS	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			
Independent Ambulation	Crutches: ☐ yes ☐ no	Braces: ☐yes ☐ no	Wheelchair: ☐yes ☐ no
Special Precautions/Needs:			

Participants with Downs Syndrome – Please Note & Complete

Due to the nature of the activity of horseback riding, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Instability. Please provide the following information:

Most recent cervical x-ray for AAI: ☐ Positive ☐ Negative Date of last x-ray:

Annual cervical exam for AAI: ☐ Positive ☐ Negative Date of last exam:

Physician's Findings

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify and check the boxes if any of the following conditions are present and explain to what degree.

Orthopedic		**Medical / Surgical**	
Atlantoaxial Instabilities		Allergies	
Coxas Arthrosis		Cancer	
Cranial Deficits		Diabetes	
Heterotopic Ossification		Hemophilia	
Hip Subluxation and Dislocation		Hypertension	
Internal Spinal Stabilization Devices		Peripheral Vascular Disease	
Kyphosis		Poor Endurance	
Lordosis		Recent Surgery	
Osteogenesis Imperfecta		Serious Heart Condition	
Osteoporosis		Stroke (Cerebrovascular Accident)	
Pathologic Fractures		Varicose Veins	
Scoliosis			
Spinal Fusion			
Spinal Instabilities/ Abnormalities			
Spinal Orthoses		**Neurologic**	
		Chiari II Malformation	
Secondary Concerns		Hydrocephalus/shunt	
Acute exacerbation of chronic disorder		Hydromyelia	
Age two - four years		Paralysis due to Spinal Cord Injury	
Behavior problems		Seizure disorders	
Indwelling catheter		Spina Bifida	
Integumentary/Skin		Tethered Cord	

Please print or stamp your name, SIGN & DATE - Thank You

To my knowledge, there is NO REASON why this person cannot participate in supervised equestrian activities. However, I understand that the final decision regarding acceptance rests with the Freedom Ride, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers and horses.

Physician Name:	Pnone:
Signature:	**Date:**
Address:	
Additional Comments:	