

TAMUS Courtney Grimshaw Fowler Equine Therapeutic Program

Program
PO Box 3266, College Station, TX 77841
Nancy Krenek, (936) 245-4489
info@courtneycares.org
Fax: (512) 863-9231 Attn: Nancy



Client / Participant Medical History & Physician's Statement

Shunt Present: Y N Date of last revision:	Client:	DOB:	Height: Weight:
Seizure Type:	Diagnosis:		Date of onset:
For Physician's Use Only: Please indicate current or past difficulties in the following systems/areas, including surgeries: Yes No Comments Auditory Visual Tactile Sensation Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Allanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Physician's Signature: Date:	Medications:	· · · · · · · · · · · · · · · · · · ·	
Special Precautions/Needs:	Seizure Type:	Controlled	: Y N Date of Last Seizure:
No	Shunt Present: Y N Date o	f lastrevision:	
For Physician's Use Only: Please indicate current or past difficulties in the following systems/areas, including surgeries: Yes	Special Precautions/Needs:		
For Physician's Use Only: Please indicate current or past difficulties in the following systems/areas, including surgeries: Yes	Mobility: Independent Ambulation	Y N Assisted A	mbulation Y N Wheelchair Y N
Please indicate current or past difficulties in the following systems/areas, including surgeries: Yes No Comments			
Auditory Visual Tactile Sensation Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Physician's Signature: Date: Pale: Please print, type or stamp		For Physiciar	ı's Use Only:
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Visual Tactile Sensation Speech Cardiac Circulatory Integumentary/Skin Immunity Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Physician's Signature: Date: Please print, type or stamp		Yes No Co	mments
Tactile Sensation Speech Carcilac Circulatory Integumentary/Skin Immunity Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Please print, type or stamp	Auditory		
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Immunity Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Physician's Signature: Date: Please print, type or stamp	•		
Pulmonary Neurological Muscular Balance Orthopedic Allergies Learning Disability Cognitive Emotional/Psychological Pain Other For those with Down Syndrome: Atlanto-Dens Interval x-rays: Date: Result: + - Neurologic Symptoms of Atlanto-Axial Instability: Physician's Statement To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program. Physician's Signature: Date:	-		
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