TAMUS Courtney Grimshaw Fowler Equine Therapeutic Program
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Fax: (512) 863-9231 Attn: Nancy

Client / Participant Medical History & Physician's Statement

Client: ______________________________ DOB: ________ Height: _________ Weight: ________________

Diagnosis: ____ Date of onset: ___________________

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

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*:* 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

Physician's Name: _________________________________ Phone: ________________________________

Address: ____

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