TAMU Courtney Grimshaw Equine Therapeutic Program
3748 F&B Road, College Station, TX 77840
Nancy Krenek, (936) 245-4489
info@courtneycares.org Fax: (512) 863-9231 Attn: Nancy

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: _____