PRAYING HANDS RANCHES, INC.

11892 E Hilltop Rd., Parker CO 80134-6029 · Phone 303-841-4043

PHYSICIAN'S INFORMATION

Client's Name _____

Problem List _____

Description of General Health Status

_____

_____

_____

Comments _____

_____

Precautions or Contraindications to any exercise or physical therapy?

_____

_____

_____

Medication List

_____

_____

_____

ALLERGIES _____

Has this person ever had an anaphylactic reaction to any substance?

☐ Yes ☐ No What was the substance? _____

Is there any reason this person should not be given epinephrine during an anaphylactic reaction? ☐ Yes ☐ No

Does this person have a history of seizure activity? ☐ Yes ☐ No

Are the seizures controlled? ☐ Yes ☐ No

Seizure Type _____

Would anything in EAAT trigger a seizure? ☐ Yes ☐ No

This information is used to evaluate a client for equine programs at Praying Hands Ranch. Completion of these forms does not guarantee acceptance into any equine programs at Praying Hands Ranch.

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Psychological level of functioning _____

Auditory defects _____

Visual defects _____

Speech defects _____

Assistive devices _____

Date of last Tetanus shot _____

Are Immunizations up to date ☐ Yes ☐ No

Trisomy 21: Yes ___ No ___ **If yes, please complete this block**

On examination of cervical spine X-rays including full flexion and full extension views, I find upon examination that the above student/client has:

☐ NO evidence of laxity of the atlantoaxial junction; no evidence of atlantoaxial subluxation.

☐ YES there is evidence of laxity of the atlantoaxial junction; and atlantoaxial subluxation.

Physician's Signature _____Date_____

PLEASE NOTE PATH international requires all riders with Down Syndrome be examined by a physician who has been briefed in the nature of atlantoaxial instability condition (AAI). The exam must include x-ray views of full extension and flexion of the neck. The x-ray procedure is the responsibility of the parents or guardian. Additionally, the rider with Down Syndrome must annually provide information from his/her Physician clearly indicating the absence of symptoms (by clinical exam only) of AAI.

The following can be contraindications for Equine Assisted Activities and Therapies (EAAT).

☐ Yes ☐ No Acute exacerbation of medical condition. (e.g. RA, MS, Diabetes)
☐ Yes ☐ No Acute herniated disc
☐ Yes ☐ No Chiari II Malformation with symptoms
☐ Yes ☐ No Coxa Arthrosis
☐ Yes ☐ No Generalized Seizures not controlled by medication
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Indwelling Urethral Catheters
☐ Yes ☐ No Pathological Fractures
☐ Yes ☐ No Tethered Cord with symptoms
☐ Yes ☐ No Unstable spine including internal hardware

If yes, please state if EAAT is contraindicated. If you would like to discuss this, email director@prayinghandsranch.org.

PHYSICIAN'S REFERRAL

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Client's Name _____

IN MY OPINION THIS PATIENT CAN RECEIVE EQUINE THERAPEUTIC RIDING UNDER APPROPRIATE SUPERVISION

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME (handwritten clearly) _____

Date _____

Address _____

City _____ Zip _____ Phone _____

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