RHYTHM OF THE REIN THERAPEUTIC RIDING AND DRIVING PROGRAM
A PATH Premier Accredited Center
PO Box 86, Waterbury Center VT 05677.
388 US Rt.2 Marshfield, Vt. 05658
802 426 3781
info@rhythmoftherein.org

PARTICIPANT MEDICAL HISTORY and PHYSICIAN STATEMENT

Participant:_____DOB:_____ Height:_____ Weight_____
Address: _____
Diagnosis(es)_____ Date of Onset: _____
Past/Prospective Surgeries: _____
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
Braces/Assistive Devices: _____

Please indicate current or past special needs in the following systems/areas, including surgeries: all YES answers require a response in the comment section.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

I have reviewed the list of precautions and contraindications to therapeutic horseback riding as listed on the following page. To my knowledge, there is no reason why this person cannot participate in supervised equine activities. I understand that the PATH center will weigh the medical information above against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Printed Name/Title: _____ MD DO NP PA Other_____UPIN:_____
Address: _____Phone: _____
Signature_____ Date: _____