



**Cloud Dancers Therapeutic Horsemanship Program, Inc.
P.O. Box 14058
Albuquerque, NM 87191**

The mission of Cloud Dancers Therapeutic Horsemanship Program, Inc., a non-profit corporation, is to empower individuals who are mentally, physically, emotionally or socially challenged through the use of PATH-approved equine experiences.

Date: Season 2017

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Participant's Medical History & Physician Statement form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	Medical/Psychological
Atlantoaxial Instability - include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Physical/Sexual/Emotional
Abuse	Skin Breakdown
Heterotopic Ossification/Myositis Ossificans	Blood Pressure Control
Joint subluxation/dislocation	Dangerous to self or others
Osteoporosis	Exacerbations of
Pathologic Fractures	medical conditions
Fire Settings	(i.e.RA,MS)
Spinal Joint Fusion/Fixation	Cardiac Conditions
Spinal Joint Instability/Abnormalities	Hemophilia
Neurologic	Medical Instability
Hydrocephalus/Shunt	Migraines
Seizure	PVD
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia	Respiratory Compromise
Substance Abuse	Thought Control Disorders
Thought Control Disorders	Recent Surgeries
Weight Control Disorders	Weight Control Disorders
Medications (i.e., photosensitivity)	Indwelling Catheters/
Poor Endurance	Medical Equipment
Indwelling Catheters/Medical Equipment	Other

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address indicated above, or leave a message at 505-926-1426.

Sincerely,

Cloud Dancers Therapeutic Horsemanship Program, Inc.

Cloud Dancers Therapeutic Horsemanship Program, Inc.
Participant's Medical History & Physician's Statement
(MUST be completed by the applicant's physician.)

Participant _____ Today's Date _____ Height: _____ Weight: _____
Birthdate: _____ Gender: M ___ F ___

Cloud Dancers Therapeutic Horsemanship Program, Inc. is a recreational horseback-riding/ other equine assisted activities program designed to benefit its riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each participant is required to furnish the following medical information before riding or participating in the program.

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Psychological: _____

Allergies (to medications or other): _____

Date of Tetanus Shot _____

Seizure Type: _____ Controlled? Y ___ N ___ Date of last seizure: _____

Shunt present? Y ___ N ___ Date of last revision: _____

Special precautions/needs _____

Current or Past Special Needs: Visual ___ Auditory ___ Neurologic ___ Muscular ___ Balance ___ Spasticity and/or Rigidity ___
Coordination ___ Circulatory ___ Cardiac ___ Pulmonary ___ Tactile Sensation ___ Integumentary/Skin ___ Immunity ___ Bones/Joint ___
Learning Disability ___ Cognitive ___ Behavioral ___ Emotional/Psychological ___ Pain ___ Communication ___ Breathing ___
Digestion ___ Elimination ___ Speech ___ Orthopedic ___ Allergies ___ Other _____

Mobility: Independent Ambulation Y ___ N ___ Assisted Ambulation Y ___ N ___ **Wheelchair** Y ___ N ___

Braces/Assistive Devices: _____

NOTE: FOR PERSONS WITH DOWN SYNDROME

DUE TO THE NATURE OF HORSEBACK RIDING, INDIVIDUALS DIAGNOSED WITH DOWN SYNDROME CAN ONLY BE ACCEPTED INTO OUR PROGRAM WITH DOCUMENTED NEGATIVE INDICATION FOR ATLANTOAXIAL INSTABILITY. I CERTIFY THAT THE PATIENT NAMED ABOVE RECEIVED A COMPLETE NEUROLOGIC EXAM THAT REVEALS NO EVIDENCE OF ATLANTOAXIAL INSTABILITY OR

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation. In my opinion the above patient named can participate in equine assisted activities for a duration of 45 - 60 minutes under appropriate supervision.

Physician Name/Title (print): _____ MD DO NP PA Other _____

Physician Signature: _____ Date: _____

Physician Address: _____ Phone: _____

License/UPIN Number: _____