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 2018
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
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Abuse
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Fire Settings
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifica/Chiari II malformation/Tethered Cord/Hydromyelia
Substance Abuse
Thought Control Disorders
Weight Control Disorders
Medications (i.e., photosensitivity)
Poor Endurance
Indwelling Catheters/Medical Equipment

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional
Skin Breakdown
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e.RA,MS)
Cardiac Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Thought Control Disorders
Recent Surgeries
Weight Control Disorders
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.

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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, INIDIVIDUALS 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: _____