Equestrian Crossings
A 501(c)(3) Non-Profit Corporation

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[rev 100515]

"Special Needs Riders ONLY"

LETTER TO PHYSICIAN

Date: _____

Dear Treatment Provider:

Your Patient, _____ has contacted our Organization and is interested in participating in supervised horse riding or other equine-related activities.

EQUESTRIAN CROSSINGS is a 501(c)3 non -profit equine-assisted activities program. We are an ALL inclusive and integrated program offering sport riding (English and Western), in - hand (ground work), vaulting, and adaptive riding lessons to all persons regardless of age or ability including those with special needs on Whidbey Island.

We are excited to be able to provide this "all-inclusive", integrated program to the people of Whidbey Island and surrounding areas.

Our lessons are available for individuals as young as 5 years old to any age for nearly all horsemanship stages, abilities and disabilities. All classes are tailored around each student's individual capabilities and skill level. No prior horse experience is necessary, only a desire to learn and have fun!

We offer individual and group classes for children, adults, individuals with "special needs" and families. Our instructors teach a variety of classes that can accommodate the desires and needs of each individual:

- Riding: For those who want to learn to ride, we offer English and Western disciplines.
- In-Hand Groundwork: For those who want to work with horses *without* riding them, we offer horsemanship groundwork, unmounted/in-hand lessons.
- Special Needs: For those with special needs, adaptive lessons in all disciplines with specially trained and certified instructors.

In order to safely provide this service, our Organization requests that you complete the attached Medical History Form.

Please note that ANY of the following conditions MAY suggest precautions and contraindications to equine-related activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

MEDICAL / PSYCHOLOGICAL

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical / Sexual / Emotional Abuse
- Blood Pressure Control
- Dangerous to Self or Others
- Exacerbation of Medical Condition (i.e., RA/MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Thought Control Disorders
- Weight Control Disorder
- PTSD

NEUROLOGIC

- Hydrocephalus / Shunt
- Seizure
- Spina Bifida / Chiari II Malformation
- Tethered Cord / Hydromyelia

ORTHOPEDIC:

- Atlantoaxial Instability – Including Neurologic
- symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossifications / Myositis Ossifications
- Joint Subluxations / Dislocations
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion / Fixation
- Spinal Joint Instability / Abnormalities

OTHER

- Age – Under 4 Years
- Indwelling Catheters / Medical Equipment
- Medications – i.e., Photosensitivity
- Poor Endurance
- Skin Breakdown

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CONSENT FOR RELEASE OF INFORMATION

I, the student/patient, hereby authorize:

_____

_ to release information from the records of:

Student's Name: _____ DOB: _____

This information is to be released to **EQUESTRIAN CROSSINGS**, for the purpose of developing an "equine activity program" for the above-named Student. The information to be released is:

Check all that apply:

- □ Medical History
- □ Physical Therapy evaluation, assessment and program plan
- □ Occupational Therapy evaluation, assessment and program plan
- □ Speech Therapy evaluation, assessment and program plan
- □ Mental Health diagnosis//treatment plan
- □ Individual Habilitation Plan (I.H.P.)
- □ Classroom Individual Education Plan (I.E.P.)
- □ Psychosocial evaluation, assessment and program plan
- □ Cognitive-Behavioral Management Plan
- □ Other: _____
- □ Other: _____

Signature: _____ Date: _____

Parent/Guardian (if a Minor)

Print Name: _____

Relationship to Student: _____

STUDENT MEDICAL HISTORY & PHYSICAL EXAM

[TO BE COMPLETED BY PHYSICIAN] –"Special Needs Riders ONLY"

Student Name: _____

General:
DOB: _____ Age: _____ Height: _____ Weight: _____ M F
Gender:
Date of Last Physical: _____ Date of Last Tetanus Shot/Immunizations: _____

Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Allergies: [Food/Drug, etc]_____

Medications: _____

Seizures: Type: _____ Controlled: Y N
Date/Severity of Last Seizure: _____
Special Precautions/Needs: _____

Mobility: Braces/Assistive Devices: _____
Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

For those with Down Syndrome:
AtlantoDens Interval X-rays, Date: _____ Results: + - _____
Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current/ past special needs in the following systems/areas, including surgeries:

SYSTEM / AREAS	YES	NO	COMMENTS *(Please be thorough)*
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
PTSD			

STUDENT MEDICAL HISTORY & PHYSICAL EXAM

[To be completed by Physician]

Student Name: _____

TO WHOM IT MAY CONCERN at EQUESTRIAN CROSSINGS:

To the best of my knowledge, as the Treatment Provider for _____, there is no reason why this person cannot participate in supervised equine activities.

However, I understand that EQUESTRIAN CROSSINGS will weigh the medical information I have given above against the existing precautions and contraindications as per NARHA/CHA/AVA guidelines.

I, therefore, 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.

Signature: _____ Date: _____

Name/Title: _____ MD DO NP PA Other: _____

Medical Facility Address: _____

City/State/Zip: _____

Phone (Work) _____ Licensed/NPI #: _____

After-Hours Emergency Number: _____

PHYSICIAN'S NOTES:

_____

_____

_____

_____

_____

_____