



HorseSense for Special Riders, Inc.
Mailing Address: P.O Box 906, La Crosse WI 54602
Physical Address: W4102 Ober Road, Coon Valley WI 54623
Phone Number: (608) 791-4868 Email: info@hssr.org

Rider's Medical History and Physician's Statement 2019

Rider Name:
DOB: Address:
Name of Parent/Guardian:

Diagnosis:
Date of onset:

HorseSense For Special Riders is a therapeutic riding program designed to benefit the 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 rider is required to furnish the following medical information before being accepted as a rider.

FOR PERSONS WITH DOWN SYNDROME:

Negative Cervical X-ray for Atlantoaxial Instability Date of X-ray

Negative for clinical symptoms of Atlantoaxial Instability

Basic Information:

Height: Weight: Seizure Type:
Controlled: Date of last seizure:

Medications(please list down below):

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

- Spinal Fusion
Osteoporosis
Spinal Instabilities / Abnormalities Atlantoaxial
Pathologic Fractures
Scoliosis
Coxal Arthrosis
Kyphosis Lordosis
Heterotopic Ossification
Hip Subluxation & Dislocation
Osteogenesis Imperfecta



HorseSense for Special Riders, Inc.
 Mailing Address: P.O Box 906, La Crosse WI 54602
 Physical Address: W4102 Ober Road, Coon Valley WI 54623
 Phone Number: (608) 791-4868 Email: info@hssr.org

NEUROLOGIC

- Hydrocephalus / Shunt
- Tethered Cord
- Spina Bifida
- Chiari II Malformation
- Hydromyelia
- Seizure Disorder
- Paralysis due to Spinal Cord injury

MEDICAL/SURGICAL

- Allergies Cancer
- Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension
- Poor Endurance Recent Surgery Diabetes
- Serious Heart Condition Stroke (Cerebrovascular Accident)

Please Indicate if patient has a problem and/or surgeries In any of the following areas by checking yes or no, If yes, please comment.

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Others			



HorseSense for Special Riders, Inc.
Mailing Address: P.O Box 906, La Crosse WI 54602
Physical Address: W4102 Ober Road, Coon Valley WI 54623
Phone Number: (608) 791-4868 Email: info@hssr.org

Mobility

	Yes	No
Independent Ambulation		
Crutches		
Braces		
Wheelchair		

Please indicate any special precautions:

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Physician Name (please print): _____ Date: _____

Physician signature: _____ Phone Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____