Thorncroft Equestrian Center
190 Line Road, Malvern, PA 19355
610.644.1963 www.thorncroft.org

Rev. 1/01/2017

Welcome Packet – New Riders

Name:_____________________________________ **Today's Date:** _______________

In order to meet the needs and develop the goals of our riders and their parents, we need the following information:

- Rider Release Form
- Medical history
- Classroom Individual Education Plan (I.E.P.)
- Physical Therapy Evaluation, Assessment and Program Plan
- Occupational Therapy Evaluation, Assessment and Program Plan
- Speech Therapy
- Mental Health Diagnosis and Treatment Plan
- Psychosocial Evaluation, Assessment and Program Plan
- Cognitive-Behavioral Management Plan
- For riders with Down Syndrome, x-rays to be re-imaged every 3 years
- For riders with Down Syndrome, a yearly neurological exam, signed and dated by a physician, stating no changes in AAI (atlantoaxial instability)
- A letter of authorization to be provided annually for riders with Down Syndrome\
- Other:____

Please check off above any of the items that are attached.

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MEDICAL HISTORY

(To be completed every 3 years)

TO BE COMPLETED AND SIGNED BY PHYSICIAN **PLEASE WRITE LEGIBLY**

NAME ___________________________DATE:_____________ PHONE: ____________________

E-MAIL ADDRESS: ____

ADDRESS: ____

DATE OF BIRTH: _________ AGE: _______SEX:______HEIGHT:_________WEIGHT:_________ (200 lb. limit)

PARENT/GUARDIAN NAME: ____

HEALTH INSURANCE COMPANY: ____________________POLICY NUMBER: ________________
Physical Disabilities: Yes_____ No _____

Intellectual Disabilities: Yes_____ No _____

Emotionally Disturbed: Yes_____No_____Learning Disabled: Yes_____No _____

DIAGNOSIS: ____

Cause: ______________________________________Onnset:_________________________

Limbs Affected: ____

If Spinal Cord Injury, what vertebral level? _______________________________________

If Down Syndrome, is Atlantoaxial Instability present (AAI):_________________________

If Down Syndrome Date of most recent Cervical Spine X-ray:________. Age at time of most recent X-ray:______

Estimate of mental ability: ____

MOBILITY STATUS:

Can the student ambulate? Yes_____ No_____

Assistance: Independent______ Minimal ______Moderate _____Maximal_____

Physical Aids: Canes ______Crutches ______Walker ______Braces______

Please describe any other additional information that might help us to work with this student.
(Medications, fears/concerns, support system, and other interests, etc.)

____

____

Physician's Signature: ____ Date: _____________

Physician's Name (Please Print): ___________________________________ Phone: ____________

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Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

Condition:	Yes	No	Description (PLEASE PRINT)
ALLERGIES			
VISION			
HEARING			
COMMUNICATION/SPEECH			
CARDIAC Pulse: Blood Pressure:			
CIRCULARTORY Hemophilia:			
PULMONARY			
METABOLIC/G.I.G.U . Diabetes, Bladder/Bowel			
SKIN & SOFT TISSUE Pressure sores			
PAST/RECENT SURGERY			Date(s)
CRONIC PAIN			
MEDICATION(S)			
NEUROLOGICAL			
SEIZURE			Controlled : Yes/No Type : Date of Last: If Yes, How often Indications of Seizures :
BEHAVIORAL			
MUSCULAR/Contractures			
SKELETAL (A) - Subluxing Hips, Fractures			
SKELETAL (B) - Scoliosis , Kyphosis , Lordosis,			Degrees:
CONTAGIOUS CONDITION			

By signing below I affirm horseback riding is NOT a contraindication for this individual.
I understand Thorncroft will weigh the medical information given against the existing precautions and contraindications. **I refer this person to Thorncroft for ongoing evaluation to determine eligibility for participation.**

Physician's Signature: ______________________________ Date: ____________

Physician's Name (Please Print):______________________________Phone:____________________

Office Name/Address: ____

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THORNCROFT - THERAPEUTIC HORSEBACK RIDING REFERRAL
PLEASE WRITE LEGIBLY AND IN DETAIL

STUDENT'S NAME: ____ **PHONE:** ______________________

DIAGNOSIS: ____ **ONSET:** _____________________

____ **ONSET:** ______________________

PRECATUTIONS:

____

____

ADDITONAL COMMENTS:

____

____

REFERRING PHYSICIAN: ____ **DATE:** __________
Please Print

Rider Questionnaire

Why will therapeutic riding be a good activity for the rider?

____

____

Are there specific goals the rider would like to achieve through therapeutic horseback riding?

____

____

What other types of therapy does the rider currently receive?

____

____

Please share with us the rider's learning style (strengths and weaknesses).

____

____

Physician's Signature: ____ **Date:**