Thorncroft Equestrian Center
190 Line Road, Malvern, PA 19355
Office: 610.644.1963 *Fax: 610.644.9342* www.thorncroft.org

Yearly Medical Update

Date: _____________

Dear Health Care Provider:

Your Patient: ___________________________________
(**Patient's name**)

Has been participating in supervised mounted equine activities at **Thorncroft Equestrian Center** and is due for an update of his/her medical status. Please review the previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, and hospitalizations, changes in medications, treatment, weight or behavior. Please indicate current height/weight. If this person has Down syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Diagnosis: ____

Height: ________________ **Weight**: _______________

Update Status (For individuals with Down Syndrome, please state any changes in AAI):
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Given the above diagnosis and medical information, this rider is eligible to continue in mounted equine-assisted activities and/or therapies. I understand that Thorncroft Equestrian Center will weigh the medical information given against the existing precautions and contraindications. I refer this rider to Thorncroft Equestrian Center for ongoing evaluation to determine continued eligibility for participation.

Print Name/Title: ___________________________________ MD DO NP PA Other ________

Signature: ____ Date: __________________

Address: ____

Phone: _________________________________ License/UPIN Number _________________