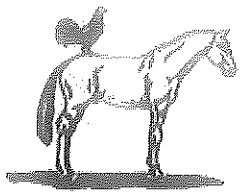

Thorncroft Equestrian Center
190 Line Road
Malvern, PA 19355
610.644.1963
www.thorncroft.org

Dear Healthcare Provider:

In order to safely provide equine-assisted therapeutic services, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note the following conditions may suggest precautions and contraindications to horseback riding and other equine-assisted activities and be advised that there is an inherent risk of injury. Therefore, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/ Myositis Ossicicans
Joint Subluxation/dislocation
Osteoporosis/Low Bone Density
Pathologic Fractures
Spinal Joint Fusion/ Fixation
Spinal Joint instability/ Abnormalities

Neurologic
Traumatic Brain Injury
Seizure Disorders
Hydrocephalus/ Shunt
Spina Bifida/ Tethered Cord /Chiari Malformation

Medical
Allergies
Asthma
Cardiac Condition
Blood Pressure Control
Exacerbation of medical condition
Hemophilia
Peripheral Vascular Disease
Lack of Trunk Stability
Lack of Head/ Neck control
Recent Surgeries

Psychological
Animal Abuse
Physical/Sexual/ Emotional Abuse
Fire Setting
Substance Abuse
Behaviors that can pose a safety risk

Other
Other Age- Under 4 years
Indwelling Catheters/ Medical Equipment
Medications- e.g. photosensitivity
Poor endurance
Skin breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Thorncroft at the address/phone indicated above.

Sincerely,

Thorncroft Program Staff

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

Rider Packet

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
- ☐ Cognitive-Behavioral Management Plan
- ☐ For riders with Down Syndrome, a **yearly** neurological exam, signed and dated by a physician, stating no changes in AAI (atlantoaxial instability).
- ☐ Other:_____

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

MEDICAL HISTORY

(To be completed every three 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:_____

PARENT/GUARDIAN NAME: _____

HEALTH INSURANCE COMPANY: _____POLICY NUMBER: _____

Physical Disabilities: Yes____ No ____

Intellectual Disabilities: Yes____ No ____

Emotionally Disturbed: Yes____No____Learning Disabled: Yes____No ____

PRIMARY 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_____Wheelchair____

Please provide additional information relevant to how we may best accommodate this student.
(Medications, fears/concerns, support system, other interests, etc. and precautions)

_____

_____

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: _____

THORNCROFT - THERAPEUTIC HORSEBACK RIDING REFERRAL

PLEASE WRITE LEGIBLY AND IN DETAIL

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).

By signature, I confirm that all attached medical information is current and accurate to the best of my knowledge.
(when this rider is attached to a form in lieu of TEC medical form , parent/guardian/caretaker assumes responsibility & risk for any incomplete medical information not brought to the attention of Thorncroft Equestrian Center & relinquishes TEC from any liability.)

Rider/Parent/Guardian (*circle one*) Signature: _____ Date: _____

Print Signature_____ Date: _____