



Ride On St. Louis

Rider's Medical History and Physician's Statement

To Be Completed Annually

Name _____ Date of Birth _____

Address _____

Name of Parent/ Guardian _____

Diagnosis _____ Date of Onset _____

****For Persons with Down Syndrome:**

Negative Cervical X-Ray for Atlantoaxial Instability X-Ray Date _____

Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: Yes No Date _____ Height _____ Weight _____

Seizure Type _____ Controlled _____ Date of last seizure _____

Medications _____

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:

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

Mobility: Independent Ambulation? Yes No Crutches? Yes No

Braces? Yes No Wheelchair? Yes No

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 of North American Riding for the Handicapped Association. I concur with an evaluation of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective Hippotherapy program.

Physician Name (please print) _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Phone () _____ DATE _____

Please See Page Two →

Ride On St. Louis Student Assessment

To Be Completed by Parent

Student's Name _____ Age _____
School Attending _____

Diagnosis: _____

Approximate Mental Age Level _____ Normal Function _____
_____ Psychosis _____ Learning Disabled
_____ Mildly Retarded _____ Moderately Retarded
_____ Severely Retarded _____ Profoundly Retarded

Does student have emotional and/or behavioral problems? _____
If yes, please explain:

Does student have a behavior management plan at school? _____

Please comment, if applicable:

Hearing: _____

Speech: _____

Vision: _____

Locomotion: _____

Special appliances used:

If non-verbal, student communicates by:

_____ Sign language _____ Gestures
_____ Communication _____ Other

Does student have any fears? _____ If yes, please explain:

Reading Ability: Can student read? _____
Reading level: _____

Brief description of student's academic skills. (What is student doing in the classroom?)

Does student have any bizarre but accepted behaviors? _____ If yes, please explain:

What behaviors should be encouraged/discouraged?
