HIGHHOPES
Horses and Humans Improving Lives℠

Date: _____

Dear Health Care Provider:

Your patient, _____ (participant's name) is interested in participating in supervised Equine Assisted Services.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to Equine Assisted Services. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurological symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure Disorder
Spina Bifida/Chiari II Malformation/
Tethered Coed/Hydromyelia

Other
Age – usually under 4 years
Indwelling Catheters/medical equipment
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (e.g., RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in Equine Assisted Services, please feel free to contact the center at (860) 434-1974.

(OVER)

PHYSICIAN'S STATEMENT FOR PARTICIPATION
**** REQUIRED FOR MOUNTED ACTIVITIES ****

Participant: _____ DOB: _____ **Height**: _____ **Weight**: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled? Y N Date of last seizure: _____
Shunt Present? Y N Date of last revision: _____
Special Precautions, Diets/Needs/Allergies: _____
Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N
Braces/Assistive Devices: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries. If yes, please comment:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:
If you prefer to provide the requested information on your own medical form, we will accept that only when comparable body systems are included, the below release section is completed, signed and dated, and your form is stapled to this High Hopes form.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that High Hopes will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc) in the implementations of an effective equestrian program.

****FOR PERSONS WITH DOWN SYNDROME:**
Neurologic symptoms of Atlanto Axial Instability: ☐ **Present** ☐ **Not Present**

___ May participate in all activities. ___ May participate except for: _____
Name/Title: _____MD DO Other: _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____