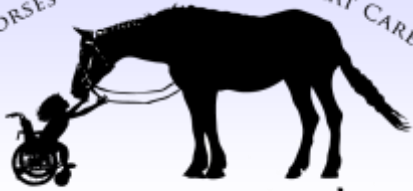


HORSES THAT HEAL HEARTS THAT CARE



THE RIGHT PATH

THERAPEUTIC EQUINE-ASSISTED PROGRAMS

at *Zuait Valley Ranch*

16620 Old Shamrock Highway Drumright, OK 74030

Date: _____

Dear Health Care Provider:

Your patient, _____
(*participant's name*)

is interested in participating in supervised equine activities. 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 activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial Instability - include neurologic symptoms
- Coxarthrosis
- Cranial Defects
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

Neurologic

- Hydrocephalus/Shunt
- Seizure
- Spina Bilida/Chiari II Malformation/Tethered Coed/Hydromelia

Other

- Age- 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 (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migranes
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- 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 activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Joshalyn Ocker
Operations Director

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

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/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: I have examined this child for Neurologic Symptoms of Atlanto Axial Instability:

(please initial) _____ Present _____ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries:

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH Int'l center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Int'l center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

Address: _____

Phone: () _____ License/UPIN Number: _____