Amy's Wish With Wings

PHYSICIAN FORM

DATE: _____

RIDER'S NAME: _____ D.O.B. _____

GENDER: ____ HEIGHT: _____ WEIGHT: _____ TETANUS SHOT ❑ NO ❑ YES DATE: _____

CONSENT TO RELEASE INFORMATION

I hereby authorize _____ to release the information from the records of
(Physician or Medical Facility)

_____ . This information is to be released to Amy's Wish With Wings for the
(Rider Name)

purpose of developing a therapeutic riding program for the named above client.

SIGNATURE: _____ DATE:_____

Dear Physician:
Amy's Wish With Wings offers an equine assisted therapeutic program designed to benefit those with deficits in numerous areas. Safety equipment such as helmets and assistance belts are used and the horses are screened and trained for special needs riders. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being considered for the program.

Diagnosis: _____ Date of onset: _____

Cause: _____

Medications (type, purpose, dose): _____

MOBILITY STATUS:

AMBULATORY: ❑ NO ❑ YES INDEPENDENT AMBULATION: ❑ NO ❑ YES

_____

_____

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CRUTCHES: ❑ NO ❑ YES BRACES: ❑ NO ❑ YES WHEELCHAIR: ❑ NO ❑ YES SITTING

BALANCED IMPAIRED: ❑ NO ❑ YES STANDING BALANCED IMPAIRED: ❑ NO ❑ YES

PLEASE INDICATE ANY SPECIAL PRECAUTIONS:

_____

_____

FOR PERSONS WITH DOWN SYNDROME:

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

Negative for Clinical Symptoms of Atlantoaxial Instability

FOR PERSONS WITH SEIZURE DISORDER:

Seizure Type:_____ Controlled: _____ Date of Last Seizure:_____

FOR PERSONS WITH SCOLIOSIS:

Degree: _____ Type: _____

PRECAUTIONS AND CONTRAINDICATION INCLUDE: (CIRCLE ALL THAT APPLY)

ACUTE MS	BLOOD PRESSURE CONTROL	OSTEOPOROSIS (SEVERE)	SPINAL FUSION
ACUTE HERNIATED DISC	COXA ARTHROSIS	OSTEOGENESIS IMPERFECTA	SPINAL INSTABILITY
ACUTE STAGE OF ARTHRITIS	CRANIAL DEFICITS	PVD	SCOLIOSIS GREATER THAN 30°
ALLERGIES	DANGEROUS TO SELF/OTHERS	RESPIRATORY COMPROMISE	SPONDYLOLISTHESIS
ANIMAL ABUSE	HEMOPHILIA	SEIZURES (UNCONTROLLED)	SUBLUXATION DISLOCATION OF JOINT
ANTI COAGULANT MEDICATION	KYPHOSIS (EXCESSIVE)	SHUNT(S)	SUBSTANCE ABUSE
ATLANTOAXIAL INSTABILITY	LOROOSIS (EXCESSIVE)	SKINBREAKDOWN	SPINABIFIDA/UNSTABLE SPINE

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Please indicate if patient has a problem or history of problems 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			

PRECAUTIONS:

_____

_____

_____

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In my opinion, there is no reason why _____ cannot receive riding therapy under the appropriate supervision.

Physician's Signature: _____ Date: _____

Physician's Name: _____
(please print)

Telephone #: _____

Address: _____
City ST Zip Code