ROCK, Ride On Center
PO Box 2422 Georgetown, TX 78627
2050 Rockride Lane, Georgetown, TX 78626
(512) 930-7625 office (512) 863-9231 fax
www.rockride.org

Participant Medical History & Physician's Statement

Participant's Name: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of onset: _____

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

***For those with Down Syndrome**:*

Neurologic Symptoms of Atlanto-Axial Instability: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Physician's Statement

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. I concur with an evaluation and treatment of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, SLP, LCSW, etc.) in the implementations of an effective equestrian program.

Physician's Signature: _____ *Date:* _____

Please print, type or stamp
Physician's Name: _____
Address: _____
Phone:_____ Fax:_____
E-mail: _____