CART Rider's Medical History and Physician's Statement – Page 1 of 2

To be completed annually

Name: ____ Date of Birth: ___________________________

Rider's Height _________________ Weight ____________________

Address: ____

Name of Parent/Guardian: ____

Diagnoses: ____________________________________ Date of Onset: __________________________

****For persons with Down Syndrome:**

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

_____ Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot _____ Yes _____ No ______ Date _________

Seizure Type ____________________ Controlled ___________ Date of last seizure ________________

Medications____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please indicate if conditions are present or if the patient has had surgeries in any of the following areas by checking yes or no. **If yes, please comment.**

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Caridac			
Circulatory			
Pulmonary			
Neurological	XXX	XXX	XXXXXXXXXXX
Hydrocephalus/shunt			
Spina Bifida			
Tethered Cord			
Chiari II Malformation			
Hydromyelia			
Paralysis due to Spinal Cord Injury			
Seizure Disorders			
Muscular			
Orthopedic	XXX	XXX	XXXXXXXXXXX
Spinal Fusion			
Spinal Instabilities/ Abnormalities			
Scoliosis			
Kyphosis			
Lordosis			
Hip Subluxation and Dislocation			
Osteoporosis			
Pathologic Fractures			
Coxas Athrosis			
Heterotopic Ossification			
Osteogenesis Imperfecta			

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Cranial Deficits			
Spinal Orthoses			
Internal Spinal Stabilization Devices			
Allergies			
Allergy to Bee Sting			
Allergy to Medication			
Diabetes			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Psychiatric Diagnoses			
Medical/Surgical	XXX	XXX	XXXXXXXXXXX
Cancer			
Poor Endurance			
Recent Surgery			
Diabetes			
Peripheral Vascular Disease			
Varicose Veins			
Hemophilia			
Hypertension			
Serious Heart Condition			
Stroke (Cerebro-vascular Accident)			
Secondary Concerns	XXX	XXX	XXXXXXXXXXX
Behavior problems			
Age under two years			
Age 2-4 years			
Acute exacerbation of chronic disorder			
Indwelling catheter			
Other			

Mobility: Independent Ambulation _____ Crutches _____ Braces _____
Wheelchair _____ Please indicate any special precautions: ______________________________________

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weight the medical information above against the existing precautions and contraindications. I concur with a review 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 equestrian program.

Physician’s Printed Name____

Physician’s Signature ____

Address __________________________ City _____________________ State________ Zip _________

Telephone number, including area code________________________ Date _______________