Physician's Assessment and Health History

~~To be completed by Physician~~

Clients Name: _____ Date of Onset: _____

Address: _____

City: _____ State: _____ Zip _____

Date of Birth: _____ Height: _____ Weight: _____

Date of last tetanus shot: _____

Diagnosis: _____ Date of Onset: _____

Primary: _____ Date of Onset: _____

Secondary: _____ Date of Onset: _____

Other: _____ Date of Onset: _____

Past/Prospective Surgeries (include dates and reasons): _____

Medications: _____

Shunts, Implants: _____

Mobility: Independent Ambulation: _____ YES ____ NO Assistive Devices: _____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply including surgeries.

Area	No	Yes	Degree/Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

Clients Name: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Results: + --

Neurological Symptoms of AtlantoAxial Instability: _____

Seizure Disorder Participants

The following information is require for clients with Seizure Disorders. Would you consider this person's seizures to be:

☐ Completely Controlled ☐ Very well controlled ☐ Fairly controlled by medication

Type of seizure: _____
Typical aura: _____
Typical motor activity during seizure: _____
Duration of seizure: _____
Current frequency of seizures: _____
Date of last seizure: _____
Description of client's behavior during post-ictal state: Post-ictal state duration:
_____
_____
_____

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that Grace Lake will weigh the medical information above against the existing precautions and contraindications.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( ) _____ License/UPIN Number: _____

Grace Lake Ministries

Clients Name: _____

Your patient is interested in participating in supervised equestrian assisted activities. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contradictions to equine activities. Therefore, when completing the attached form please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial instability- include neurological symptoms
Coxa Arthritis
Cranial Defects
Heterotopic ossication/Myositis Ossificans
Osteoporosis
Pathological Fractures
(i.e. RA, MS)
Spinal Joint Fusion/Fixation
Spinal Join Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation
Tethered Cord/Hyropmyelia

Other

Age – Under 4 Yrs. old
Indwelling Catheters/Medical Equipment
Medication – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Pathological

Allergies
Animal Abuse
Cardiac Conditions
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self and others
Exacerbation of medical conditions

Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 Grace Lake Ministries.

Rider's Application and Health History

GENERAL INFORMATION

Rider: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender M F

Address: _____ City: _____ Zip:_____

Phone: _____ _____ E-mail: _____ ___

Employer/School: _____Phone #: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

How did you hear about the program? _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription, over-the-counter; name, dose, and frequency) _____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns/etc.) _____

_____

_____

_____

_____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?) _____

_____

_____

_____

_____

LIABILITY RELEASE

_____ (Rider's Name) would like to participate in the Grace Lake Ministries Horsemanship Program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Grace Lake Ministries, its Board of Directors, Instructors, Therapists, Aids, Horse Owners Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Grace Lake Ministries Horsemanship programs.

WARNING – *Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a rider in equine activities resulting from the inherent risks of equine activities.*

Signature: _____ Date: _____

Rider, Parent, Legal Guardian

PHOTO RELEASE

I DO

DO NOT

Consent to and authorize the use and reproduction by Grace Lake Ministries of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____ Rider, Parent, Legal Guardian