Valley Riding Inc.

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Ensuring excellence and changing lives through equine-assisted activities and therapies

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 and Needs:_____
_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/ Assistive Devices:_____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	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 Intl. Center will weigh the medical information given against the existing precautions and contradictions. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO PA NP Other _____
Signature: _____ Date: _____
Address: _____
Phone: _____ License/UPIN Number: _____