Valley Riding, Inc.
19901 Puritas Ave.
Cleveland, OH 44135
216-267-2525
216-267-9743 (fax)

Valley Riding, Inc.
Physician's Statement
(To be completed annually)

Name: ______________________________ Date of Birth: ______________

Address: ______________________________

Name of Parent/Guardian: ______________________________

Diagnosis: ______________________________ Date of Onset: ______________

•• For *Persons with Down Syndrome:*

Negative Cervical X-ray for Atlantoaxial Instability. X-ray date__________________

Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot: Yes No Date _______________ Height ___________ Weight ______________

Seizure Type ____________ Controlled ___________________ Date of last seizure ______________

Medications______________________________

Please indicate if patient has a problem 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 Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes No Crutches Yes No Braces Yes No

Wheelchair Yes No Please indicate any special precautions: ____________________

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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 a review of the 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 Name (please print) ______________________________

Physician Signature ______________________________

Address ______________________________ City _____________ State _______ Zip ____________

Phone ______________________________ Date ______________________________

Please See Other Side

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding: Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Paralysis due to Spinal Cord injury
Seizure Disorders

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior problems
Age under two years
Age two – four years
Acute exacerbation of chronic disorder
Indwelling catheter

Please See Other Side