SunCatcher Therapeutic Riding Academy, Inc.
P O Box 3975, Rapid City, SD 57709
1-605-939-4907
SunCatcherRiding@gmail.com
www.suncatchertra.org

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____
Shunt Present: ☐ Yes ☐ No Date of last revision: _____
Special Precautions/Needs: _____

Mobility: Independent Ambulation ☐ Yes ☐ No Assisted Ambulation ☐ Yes ☐ No Wheelchair ☐ Yes ☐ No
Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: ☐ + ☐ -
Neurologic Symptoms of AtlantoAxial 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			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

I understand that this individual is considering participating in a supervised equestrian program. I have knowledge of this individual and his/her current medical condition and have reviewed the list of precautions and contraindications on the reverse side of this form and indicated whether these conditions are present.

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