SunCatcher Therapeutic Riding Academy
P.O. Box 3975
Rapid City, SD 57709

Site Location: 23325 S. Airport Rd – Rapid City, SD
Phone: (605) 939-4907
E-mail: SunCatcherRiding@gmail.com
Website: www.SunCatcherTRA.org
Fax: 1-605-853-7153

Date_____

Dear Physician:

Your Patient, _____, is interested in
(Participant's Name)
participating in supervised equestrian activities.

In order to safely provide the service, our Center requests that you complete/ update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these condition are present, and to what degree.

Orthopedic	Medical / Psychological
Atlantoaxial Instability-include neurologic symptoms	Allergies
Coxa arthrosis	Animal Abuse
Cranial Deficits	Physical / Sexual / Emotional Abuse
Heterotopic Ossification / Myositis Ossificans	Blood Pressure Control
Joint subluxation / dislocation	Dangerous to self or others
Osteoporosis	Exacerbation of medical conditions
Pathologic Fractures	Fire Settings
Spinal Fusion / Fixation	Heart Conditions
Spinal Instability / Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus / Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Chiari II malformation/Tethered Cord/ Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorders
Age – under 4 years	Weight Control Disorder
Indwelling Catheters	
Medications – i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

Thank you very much for your assistance If you have any questions or concerns regarding this patient's patient's participation in therapeutic equine activities, please feel free to contact the center at the address / phone indicated abo

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/ AREA, INCLUDING SURGERIES:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Pulmonary			
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: _____ Licensed/ UPIN Number: _____