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: info@SunCatcherTRA.org
Website: www.SunCatcherTRA.org

Dear Physician:

Your Patient, _____(participant's name) is interested in participating in supervised equestrian activities with SunCatcher Therapeutic Riding Academy, Inc.

In order to safely provide the service, we request 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 equine-assisted horsemanship and riding.** Therefore, when completing this form, please note whether these conditions 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 participation in therapeutic equine activities, please feel free to contact the center at the address / phone indicated above.

Participant's Medical History and Physician's Statement

To be completed by Primary Care Provider. Please fill out completely.

Can be faxed to: (605) 853-7153

Participant: _____ DOB: _____

Age: _____ Height: _____Weight: _____ Tetanus Shot (circle) Y/N Date of last Tetanus shot: _____

Diagnosis: _____

Seizure Type: _____ Controlled: Y/N Date of last seizure: _____

Medications: _____

****For persons with Down Syndrome: ****

Cervical X-ray for Atlantoaxial Instability _____Positive _____Negative X-Ray Date_____

PLEASE INDICATE PROBLEMS and/or SURGERIES IN THE FOLLOWING AREAS:

AREAS	YES	NO	COMMENT
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Pulmonary			
Other			

Mobility: Independent Ambulation: Y/N Crutches: Y/N Braces: Y/N Wheelchair: Y/N

Approved for Mounted Horseback Activity: Y/N Special Precautions: _____

_____

Physician's Statement: To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. (See accompanying letter for precautions and contraindications.) This client has my permission to participate in SunCatcher's Therapeutic Horsemanship program(s) under appropriate supervision.

Recommended Frequency: (One hour/1x/week is standard) _____

This release is valid for the period of: (please circle only one) 1 year 2 years 3 years

Physician Signature_____ Date_____

Please print or stamp: Physician Name_____ Phone_____

Address _____City_____State_____Zip_____