



PHYSICIAN RELEASE FORM

DATE: _____

RIDERS NAME: _____ D.O.B: _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____ TETANUS SHOT: NO YES DATE: _____

NAME OF PARENT/GUARDIAN _____

CONSENT FOR RELEASE OF INFORMATION:

I hereby authorize _____ to release the information from the records
(physician or medical facility)
of _____. This information is to be released to Rocky Top Therapy
(riders name)
Center for the purpose of developing a therapeutic riding program for the above named client.

SIGNATURE: _____ DATE: _____

Dear Physician: Rocky Top Therapy Center offer an equine assisted therapeutic program designed to benefit those with deficits in numerous areas. Safety equipment such as helmets and assistance belts are used and the horses are screened and trained for special needs riders. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being considered for the program.

Diagnosis: _____ Date of onset: _____

Cause: _____

Medications (type, purpose, dose):

Mobility Status:

Ambulatory: yes no **Independent Ambulation:** yes no **Crutches:** yes no **Braces:** yes no
Wheelchair: yes no **Sitting Balance Impaired:** yes no **Standing Balance Impaired:** yes no

Please indicate any special precautions:

For persons with Down Syndrome:

Negative Cervical X-Ray for Atlantoaxial Instability, X-Ray Date: _____

Negative for Clinical Symptoms of Atlantoaxial Instability

For persons with Seizure disorder:

Seizure Type: _____ Controlled: _____ Date of last seizure: _____

For persons with Scoliosis:

Degree: _____ Type: _____

PRECAUTIONS AND CONTRAINDICATIONS INCLUDE (circle all):

| | | | |
|---------------------------|--------------------------------------|-------------------------|----------------------------------|
| ACUTE MS | BLOOD PRESSURE CONTROL | OSTEOPOROSIS (SEVERE) | SPINAL FUSION |
| ACUTE HERNIATED DISC | COXA ARTHROSIS (degeneration of hip) | OSTEOGENESIS IMPERFECTA | SPINAL INSTABILITY |
| ACUTE STAGE OF ARTHRITIS | CRANIAL DEFICITS | PVD | SCOLIOSIS GREATER THAN 30' |
| ALLERGIES | DANGEROUS TO SELF/OTHERS | RESPIRATORY COMPROMISE | SPONDYLOLISTHESIS |
| ANIMAL ABUSE | HEMOPHILIA | SEIZURES UNCONTROLLED | SUBLUXATION DISLOCATION OF JOINT |
| ANTI COAGULANT MEDICATION | KYPHOSIS (EXCESSIVE) | SHUNT (S) | SUBSTANCE ABUSE |
| ATLANTO-AXIAL INSTABILITY | LORDOSIS (EXCESSIVE) | SKIN BREAKDOWN | SPINA BIFIDA UNSTABLE SPINE |

Please indicate if patient has a problem or history of problems 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 DISABILITY | | | |
| MENTAL IMPAIRMENT | | | |
| PSYCHOLOGICAL IMPAIRMENT | | | |
| OTHER | | | |

In my opinion, there is no reason why _____ cannot receive riding therapy under the appropriate supervision.

Precautions:

Physician's Signature _____ Date: _____

Physician's Name: _____
(please print)

Telephone #: _____

Address: _____
City Zip Code

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE) AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

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