Trinity Equestrian Center – Medical Release

Fax #: 715-832-3229

Patient Name _____Date _____

Patient Address _____City_____State_____Zip Code_____

Patient Phone _____

Last recorded height _____ Date _____ Last recorded weight (Limit 190#)_____ Date _____

Primary Diagnosis _____Date of onset _____

Secondary Diagnosis _____ Date of onset _____

Past/Prospective Surgeries _____

Shunt present? ☐ Yes ☐ No If yes, date of last revision _____

Seizures? ☐ Yes ☐ No Controlled? ☐ Yes ☐ No Date of last seizure _____

Medications and what they are for _____

_____

Ambulation ☐ Independent ☐ Assisted ☐ Wheelchair

Incontinence? ☐ Yes ☐ No Tetanus Shot? ☐ Yes ☐ No Date _____

Special precautions _____

_____

Auditory	☐ Yes ☐ No	Comment _____
Visual	☐ Yes ☐ No	Comment _____
Speech	☐ Yes ☐ No	Comment _____
Cardiac	☐ Yes ☐ No	Comment _____
Circulatory	☐ Yes ☐ No	Comment _____
Pulmonary	☐ Yes ☐ No	Comment _____
Neurological	☐ Yes ☐ No	Comment _____
Muscular	☐ Yes ☐ No	Comment _____
Orthopedic	☐ Yes ☐ No	Comment _____

Learning disability or Emotional/Behavioral disorder _____
_____

Please Note: for individuals with Down Syndrome only

Because of the nature of the horseback riding activity, no individual diagnosed with Down Syndrome can be accepted for riding instruction without the proof of a negative diagnostic x-ray for Atlantoaxial Dislocation Condition.

Medical Acknowledgement:

I have x-rayed this patient for Atlantoaxial Dislocation Condition and the results are negative. In addition, this patient does not display signs or symptoms of ADC and may participate in the Trinity Equestrian Center Adaptive Riding/Equine Workshops Programs.

Date of last x-ray _____

Authorization

☐ Yes, in my opinion this patient can participate in the Trinity Equestrian Center Adaptive Riding Program and/or Equine Workshops, under appropriate supervision.

☐ No, in my opinion this patient should not participate in the Trinity Equestrian Center Adaptive Riding Program and/or Equine Workshops.

General Comments _____
_____
_____

Medical Signature _____ Date _____