Rundle Riders Therapeutic Riding

Interested participants must complete and submit this 2 page form to Rundle Riders Therapeutic Riding. Completion of application forms *does not ensure acceptance* into a riding program.

Participant Application and Medical History Form

Name of Participant: _____

Date Of Birth:_____ **Height:**_____ **Weight:**_____

Guardian(s) Name(s):_____

Address: _____

City: _____ **Postal Code:** _____ **Home Tel:** _____

Health Insurance Company:_____ **Policy #:** _____

Physicians Name: _____ **Tel:** _____

Physicians Address: _____

Preferred Medical Facility: _____

Have you discussed, and gain approval and consent from your physician regarding your specific participation in Horseback riding activities?: **Yes**_____ **or No**_____

******Note: You must have your physician fill out and initial the Professional Medical Statement on page 2.***

Diagnosed Illnesses: _____
_____

Past/Prospective Surgeries: _____
_____

Allergies *(medical and environmental)*: _____
_____

Current Medications *(Include both prescription and non-prescription herbs and supplements with name, dose, and frequency):*
_____
_____
_____

Impairments in Dexterity, Flexibility, Movement *(mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*:
_____
_____
_____

Psycho/Social Function *(Work/School grade completed, leisure interests, relationship family-structure, support systems, companion animals, fears/concerns)*:_____
_____
_____

Assistance required/Assistance Equipment required *(include all assisted required or equipment needed)*: _____
_____
_____

Goals *(why are you applying for participation? What would you like to accomplish?)*: _____
_____
_____

Past or Current Special Needs	*Yes*	*No*	*Comments*
Vision/Visual			
Hearing/Auditory			
Sensation/Tactile Sensation			
Heart/Cardiac			
Breathing/Pulmonary			
Digestion/Gastrointestinal			
Elimination/Incontinence			
Circulatory			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognitive function			
Allergies			
Immunity			
Neurological			
Balance			
Orthopedic			
Learning Disability			
Independent Ambulation			
Assisted Ambulation			
Wheelchair			
Braces/Assistive Devices			
Downs Syndrome: AtlantoDens Interval x-ray date and results (+ or -)			
Other			

Participant Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Professional Medical Statement

** To Be Filled Out By Supervising Medical Professional**

To my knowledge, there is no reason why this person cannot participate in supervised equine activities and horseback riding. I understand that Rundle Riders Therapeutic Riding. weighs the medical information provided above, against the existing precautions and contraindications prior to any participant's acceptance into a riding program.

I concur with this person's abilities to participate in (please initial)**:** _____ **Participate in Horseback Riding**
_____ **Equine Assisted Activities.**

Please note any additional Information that is incomplete or not mentioned above: _____

_____

_____

Name: _____ **Title:** _____
First and Last name *professional title eg. MD, PT, OT*

Signature: _____ **Date**: _____

Address: _____

Telephone: (_____) _____**--**_____ **Email:** _____