THE RIGHT STEP, INC.

THE HEALING POWER OF HORSES

A PATH Intl. Premier Therapeutic Riding Program

Client's Medical History & Physician's Statement

(To be completed by Client's Physician)

Client: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Allergies: _____

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

*****For clients with DOWN SYNDROME*****

An annual neurological exam to exclude Atlantoaxial instability is required for all participants with Down Syndrome. Please provide the following information:

Date of Exam _____ Results of Exam _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that The Right Step, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The Right Step, Inc. for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Please return this form to:

The Right Step, Inc.
P.O. Box 721
Littleton, CO 80160-0721
Attn: Program Director