Participant's Medical History and Physician Statement
(Form 6)

To be completed and *signed* by the Participant's Physician)

Participant: ______________________ DOB: ______________________

Height: ______________________ Weight: ______________________

Address: ______________________ City: ____________ State:____ Zip: ____________

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: ______________________

Special precautions/needs: ______________________

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

Braces/Assistive Devices: ______________________

For those with Down Syndrome: AtlantoDens Interval X-rays, Date: __________ Result + -

Neurological Symptoms of AtlantoAxial Instability: ______________________

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			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: ______________________ MD DO NP PA Other ____________

Signature: ______________________ Date: ______________________

Address: ______________________

Phone: ______________________ License/UPIN Number: ____________

Updated for the year 2013 to conform to the latest PATH International Standards & Accreditation Manual