

### Physician's Consent

Participant: \_\_\_\_\_ 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: \_\_\_\_\_  
 Special Precautions/Needs: \_\_\_\_\_  
 Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N  
 Braces/Assisted Devices: \_\_\_\_\_  
*For those with Down Syndrome:* Atlanto Dens Interval X-ray, date: \_\_\_\_\_ Result: + -  
 Neurological Symptoms of Atlanto Axial 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			
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 Ivey Ranch Park Assoc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Ivey Ranch Park Equestrian Programs for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_