



4STEP 4 Seasons Therapeutic Equestrian Program

MEDICAL HISTORY & PHYSICIAN'S RELEASE

Participant Name _____

Address _____

Phone Number _____

Date of Birth _____

Age _____

Parents/Caregiver _____

Diagnosis _____

Date of Onset _____

****FOR PERSONS WITH DOWNS SYNDROME****

Cervical X-ray for Atlantoaxial Instability: Positive Negative Date of X-ray _____

Tetanus Shot: Yes No Date _____ Height _____ Weight _____

Seizure?: Yes No If yes, controlled? Date of last seizure _____

Medications: _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: Yes No Crutches: Yes No Wheelchair: Yes No

Please indicate any special precautions by checking here _____ and detailing on the back of this form.

In my opinion, this patient can participate in supervised equestrian activities as described by 4STEP. I refer / do not refer the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

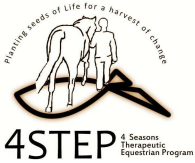
Physician Name (Please Print) _____

Signature _____

Practice Name _____

Phone Number _____

Date _____



MEDICAL HISTORY & PHYSICIAN'S RELEASE

Health History

To be completed by the participant/parent/legal guardian.

Please circle the participants current special needs in the following areas. Use space provided below to comment or explain as necessary.

Vision Hearing Sensation Communication Heart Breathing Digestion Elimination
Circulation Emotional/Mental Health Behavioral Pain Bone/Joint Muscular
Thinking/Cognition Allergies Other

Describe abilities/difficulties in the following areas (include assistance required or equipment needed):

Psycho/Social Function (interests, fears/concerns, etc)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Signature _____ Date _____

**Please use the back of this form if you need more space for explanation.