True Strides
10509 108th Street NW
Annandale, MN 55302
registration@truefriends.org
www.truestrides.org

SEND TO PHYSICIAN

Contraindications to Equine Activities

Date:

Dear Health Care Provider,
Your patient,_____ *(participant's name)* is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/email indicated above.

Sincerely,

Director of True Strides

Orthopedic	NO	YES	COMMENTS
Atlantoaxial Instability - include neurologic symptoms	☐	☐	
Coxa Arthrosis	☐	☐	
Cranial Deficits	☐	☐	
Heterotopic Ossification/Myositis Ossificans	☐	☐	
Joint subluxation/dislocation	☐	☐	
Osteoporosis	☐	☐	
Pathologic Fractures	☐	☐	
Spinal Joint Fusion/Fixation	☐	☐	
Spinal Joint Instability/Abnormalities	☐	☐	
Neurologic	☐	☐	
Hydrocephalus/Shunt	☐	☐	
Seizure	☐	☐	
Spina Bifida/Chiari II malformation	☐	☐	
Tethered Cord/Hydromyelia	☐	☐	
Medical/Psychological	☐	☐	
Allergies	☐	☐	
Animal Abuse	☐	☐	
Cardiac Condition	☐	☐	
Physical/Sexual/Emotional Abuse	☐	☐	
Blood Pressure Control	☐	☐	
Dangerous to self or others	☐	☐	
Exacerbations of medical conditions (i.e. RA, MS)	☐	☐	

	No	Yes	COMMENTS
Fire Settings	☐	☐	
Hemophilia	☐	☐	
Medical Instability	☐	☐	
Migraines	☐	☐	
PVD	☐	☐	
Respiratory Compromise	☐	☐	
Recent Surgeries	☐	☐	
Substance Abuse	☐	☐	
Thought Control Disorders	☐	☐	
Weight Control Disorder	☐	☐	
Other	☐	☐	
Age - under 4 years	☐	☐	
Indwelling Catheters/Medical Equipment	☐	☐	
Medications - i.e. photosensitivity	☐	☐	
Poor Endurance	☐	☐	
Skin Breakdown	☐	☐	
	☐	☐	

Please provide your professional opinion as to weather or not your patient is a suitable candidate for mounted horseback riding activities:

_____

Physician's Signature **Date**

_____

Physician's Printed Name

Thank you for your assistance.

Please send materials at least three (3) weeks prior to camp to:

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