RHYTHM OF THE REIN THERAPEUTIC RIDING PROGRAM


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HEALTH HISTORY FOR ALTERNATIVE RIDING PROGRAM

Name _____ DOB _____
Height _____ Weight _____ (*used to determine appropriate horse*)
Parent or Guardian _____ Phone _____
Address _____
Medical Insurance Co. _____ Policy # _____
Ins Co. Phone # _____ Group # _____

List any medical conditions _____
_____
_____

(if Downs Syndrome, attach MD certification of absence of atlanto-axial instability)

Allergies _____

Medications _____

Emergency Contact Name _____ Phone _____
Physician Name _____ Phone _____

Physical functional abilities (walking, transfers, devices used, continence, etc.) _____
_____
_____

Psychosocial (school, work, leisure activities, fears, concerns) _____
_____
_____

Goals (what would you like to accomplish?) _____
_____
_____

I attest I have disclose any medical conditions that may affect my ability to participate in Equine Assisted Activities.

_____ _____
Participant, Parent, or Legal Guardian Date