Physician Consent Form

Participant's name: _____ DOB: _____

Parent/Guardian name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ **CURRENT HEIGHT**: _____ **CURRENT WEIGHT**: _____LBS.

170-LB WEIGHT LIMIT DEPENDANT UPON AMBULATORY STATUS, ROM, AND THERAPIST DISCRETION

Pegasus Springs is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possibly protection and greater personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

NOTE: ***BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGIC EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI)***

Diagnosis: _____ **Date of onset**: _____

IF DIAGNOSIS IS DOWN SYMDROME, THIS FORM MUST BE ACCOMPANIED BY A SIGNED AND DATED STATEMENT FROM THEIR PHYSICIAN THAT DENIES ANY SYMPTOMS CONSISTENT WITH AAI.

Does this person demonstrate explosive/violent behavior or the potential for explosive/violent behavior? Yes___No___ If Yes, please explain:

_____

_____

Medical History:

_____

_____

Surgical Procedures:

_____

_____

Medications:

_____

_____

Defects present in: ○ Sight ○ Hearing ○ Speech ○ Balance ○ Neuro-sensation

○ Muscle Tone ○ Coordination ○ Mobility

Braces or assisted devices used? NO _____YES: _____ Is the participant ambulatory? YES_____ NO_____

Comment if applicable:

Seizures:_____

Incontinence:_____

General comments: _____

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION

Physician signature: _____ Date: _____

Physician's printed name: _____Phone: _____

Address: _____ City: _____ Zip: _____