WILLOW CREEK RANCH, INC.
Therapeutic Riding Center

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Ensuring excellence and changing lives through equine-assisted activities and therapies

Dear Healthcare Provider:

Your patient, _____ DOB: _____
(Participant's Name)

is interested in participating in supervised equine activities at Willow Creek Ranch, Inc.

In order to safely provide this service, our center requests that you complete/update the attached Participant 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.

Orthopedic
Atlantoaxial Instability – include Neurologic symptoms
Coxarthrosis
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 Bilfida

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications –e.g. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of medical conditions (e.g. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact me directly by phone at 414-791-2509.

Sincerely,

Jennifer Pape, WCR Founder
PATH Intl. Certified Therapeutic Riding Instructor

Return Participant Medical History & Physician's Statement form to:
Willow Creek Ranch
7404 Northwest Hwy 83
Mukwonago, WI 53149