

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