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

Participant Medical History and Physician's Statement

Participant Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past Surgeries/Hospitalizations: _____

Seizure Type: _____ Controlled: □ Yes □ No Date of Last Seizure: _____

Shunt Present: □ Yes □ No Date of Last Revision: _____ Special Precautions/Needs: _____

Mobility: Independent Ambulation: □ Yes □ No Assisted Ambulation: □ Yes □ No Wheelchair: □ Yes □ No

Braces/Assistive Devices: _____

For those with Down Syndrome: Neurologic symptoms of Atlantoaxial Instability: □ Present □ Absent

Please indicate current or past special needs in the following systems/areas including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Yes	No	Comments
Allergies			
Balance			
Behavioral			
Breathing			
Circulatory			
Cognitive/Thinking			
Digestion			
Emotional/Psychological			
Hearing			
Heart			
Immunity			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Skin Condition			
Speech			
Tactile Sensation			
Visual			
Other			

Other information you would like to share (e.g. medications):

_____

_____

_____

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Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine-assisted activities. I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Print Name/Title: _____ MD DO NP PA Other:_____

Signature: _____ Date: _____

Address: _____

Phone: _____

License/UPIN Number:_____License Expiration: _____