Medical Release Form

Équi-Libre Therapeutic Riding Centre

## Client / rider information

| Name: | Date of birth: |
|---|---|

## Medical information

| | |
|---|---|
| Primary diagnosis: | |
| Secondary diagnosis: | |
| Height: | Weight (max 160lbs): |
| Cerebral Palsy: ◯ YES / ◯ NO If yes, please specify: Monoplegia, Diplegia, Quadriplegia, Hemiplegia (which side L / R) | |
| Diabetic: ◯ YES / ◯ NO | Insulin: ◯ YES / ◯ NO |
| Ambulatory: ◯ YES / ◯ NO If no, please indicate equipment used: | |
| Medication: ◯ YES / ◯ NO If yes, please specify: | |
| Allergies: ◯ YES / ◯ NO If yes, please specify | Epipen: ◯ YES / ◯ NO |

## Other pertinent information

| | |
|---|---|
| Muscle tone in upper extremities (good / fair / poor): | |
| Muscle tone in lower extremities (good / fair / poor): | |
| Tone in trunk (good / fair / poor): | |
| Spasticity: | |
| Coordination: | |
| Balance: | |
| Language(s) spoken / understood: | |
| Speech (good / fair / poor): | Ability to understand (good / fair / poor): |
| Vision (good / fair / poor): | Hearing (good / fair / poor): |
| Sensory sensitivity: | |
| Communicable disease(s): ◯ YES / ◯ NO If yes, please specify: | |
| Surgical history & dates: | |

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ÉQUI-LIBRE
CENTRE D'ÉQUITATION THÉRAPEUTIQUE

## Atlanto-axial x-ray verification

Due to the nature of this activity (horseback riding), Down Syndrome with an atlanto-axial instability is a contraindicated condition. A negative atlanto-axial instability x-ray is required. If the rider has Down Syndrome this form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray.

◯ This client does not have Down Syndrome
◯ This client has Down Syndrome

Date of X-ray:

Result of X-ray:

## Seizure policy

Due to the nature of this activity (horseback riding), participants with a seizure disorder will not be permitted to participate in mounted activities if they have had a seizure in the last 12 months (unmedicated), or 6 months (medicated).

◯ This client does not have a seizure disorder
◯ This client has a seizure disorder

If yes, please specify type and frequency of seizures:

Currently taking medication to control seizures: ◯ YES / ◯ NO

Date of last seizure:

The undersigned hereby acknowledges that ______________________________ is medically able to participate in the equestrian program / receive services offered by Équi-libre Therapeutic Riding Centre.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic center will weigh the medical information above against existing therapeutic riding precautions and contraindications. Assessment of this person's abilities / limitations for the purpose of implementing an effective equestrian program is the responsibility of the center.

Note: In the case of a physical disability, this form must be signed by a medical doctor. For all non-physical disabilities, this form can be signed by an occupational therapist or physical therapist with good knowledge of the individual.

Physician / health professional's name & title: ______________________________

Signature: ______________________________ Date: ______________

Physician / health professional's address: ______________________________

Phone: ______________ Email: ______________________________

Parent/guardian name: ______________________________

Signature: ______________________________ Date: ______________