Medical Release Form

Équi-Libre Therapeutic Riding Centre

ÉQUI-LIBRE
CENTRE D'ÉQUITATION THÉRAPEUTIQUE
THERAPEUTIC RIDING CENTER

Client / rider information	
Name:	Date of birth:

Medical information	
Primary diagnosis:	
Secondary diagnosis:	
Height:	Weight (max 180lbs):
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 yes, please specify:	☐ Epipen

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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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:

Name (name of parent/guardian if applicable): _____

Signature: _____ **Date:** _____

In the case of a rider with 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 (if you have access to one).

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.

Physician / health professional's name & title: _____

Signature: _____ **Date:** _____

Phone: _____ **Email:** _____