

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Health Care Provider:

Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is interested in participating in Macon TRACS’s supervised equine activities. Most activities the student is mounted on the horse if all safety requirements are met.

In order to safely provide this service, Macon TRACS requests that you complete/update the attached **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 Medical / Psychological**

Atlantoaxial Instability - include neurologic symptoms Allergies

Coxarthrosis Animal Abuse

Cranial Defects Cardiac Condition

Heterotopic Ossification/Myositis Ossificans Physical/Sexual/Emotional Abuse

Joint subluxation/dislocation Blood Pressure Control

Osteoporosis Dangerous to Self or Others

Pathologic Fractures Exacerbations of Medical Conditions (e.g., RA, MS)

Spinal Joint Fusion/ Fixation Fire Settings

Spinal Joint Instability /Abnormalities Hemophilia

 Medical Instability

**Neurologic** Migraines

Hydrocephalus/Shunt PVD

Seizure Respiratory Compromise

Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia Recent Surgeries

 Substance Abuse

**Other** Thought Control Disorders

Age - under 4 years Weight Control Disorder

Indwelling Catheters/Medical Equipment

Medications - e.g., Photosensitivity

Poor Endurance

Skin Breakdown

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.

Sincerely,

Jan McGee

828-421-0265

Macon TRACS, Inc**. T**herapeutic **R**iding for **A**dults’ and **C**hildren’s **S**uccess P.O. Box 101, Otto, NC 28763 828-349-6262