



Participant's Medical Clearance and Physician Statement

**To be completed and signed by the
Participant's Physician**



Participant: _____ DOB: _____

Height: _____ Weight: _____

Address _____ City: _____ State _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special precautions/needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down syndrome: Result of Neurological exam of Atlantoaxial Instability: _____ Present _____ Absent

Please indicate current or past special needs in the following system/areas, including surgeries:

	Y	N
Auditory		
Visual		
Tactile Sensation		
Speech		
Cardiac		
Circulatory		
Integumentary/Skin		
Immunity		
Pulmonary		
Neurological		
Muscular		
Balance		
Orthopedic		
Allergies		
Learning Disability		
Cognitive		
Emotional/Psychological		
Pain		
Other		

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN number: _____