Winslow THERAPEUTIC CENTER "Healing with Horses" SINCE 1974

Participant's Medical Clearance and Physician Statement

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

PREMIER ACCREDITED CENTER PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

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: _____