

The Red Barn
2700 Bailey Road, Leeds, AL 35094

Participant's Medical History & Physician's Statement COMPLETED BY MEDICAL PROFESSIONAL

Participant:		DOB:	Weight:
Address:		School:	
Diagnosis:		Date of Onset:	
Past/Prospective Surgeries:			
Medications:			
SeizureType: seizure:		Controlled: Y N	Date of last seizure:
Shunt Present: Y N		Date of last revision:	
Special Precautions/Needs:			
Braces/Assistive Devices:			
<i>For those with Down Syndrome: AlantoDens Interval x-rays,</i>		Date:	Result: + --
Neurological Symptoms of AlantoAxial Instability:			

****Please indicate current or past difficulties in the following systems/areas surgeries:**

	Y	N	Please Describe
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 equestrian activities by The Red Barn.

Name/Title:	MD DO NP PA Other:
Signature:	Date:
Address:	
Phone: ()	Evening: ()

Notes: