The Red Barn
Faith, Hope & Love

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, The Red Barn 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:
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic:
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other:
Age – under 4 year
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological:
Allergies Animal Abuse Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please contact us at Info@TheRedBarn.org or call (205) 699-8204.

The Red Barn
2722 Bailey Road, Leeds, AL 35094

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

Participant:_____ DOB: _____ Height: _____ Weight: _____

Address: _____ School: _____

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: _____

Braces/Assistive Devices: _____

For those with Down Syndrome: AlantoDens Interval x-rays: Y N Date: _____ Result: Positive Negative

Neurological Symptoms of AlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that The Red Barn will weigh the medical information given against the existing precautions and contraindications, Therefore, I refer this person to The Red Barn for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____

License/UPIN Number: _____ Phone: _____ Evening: _____

Address: _____

Signature: _____ Date: _____