Physician Release for High Hurdles Riding Program

Dear Dr. _____

The individual listed below has indicated that you are their primary physician. They have shown an interest in participating in our therapeutic horsemanship program. Please provide us with your recommendations regarding the activity/exercise prescription for this individual and any restrictions and/or limitations that would limit their participation in this program. Thank you for your cooperation.

Participant's name: _____

Diagnoses: _____
_____

Past / Prospective Surgeries: _____
_____

Seizures / type? _____ Date of Most Recent Sz: _____

For those with Down syndrome, they must have a negative cervical spine x-ray in order to ride.
Down syndrome: *(circle one) yes no* If yes, date of cervical spine x-ray: _____ Result: _____

Are there any limitations to on-horse or riding activities?
Yes _____ No _____

Please check any limitations to any muscle strength activation movements or limited mobility:

Chest : ____	Shoulders: _____
Back: ____	Hips: _____
Bicep: ____	Legs: _____

Are there any limitations to any Cardiovascular and or Endurance training exercises, primarily during periods of walking or jogging?
Yes _____ No _____

Physician's Recommendation

____ I am not aware of any contraindications in participating in this horsemanship program
____ I believe this individual can participate, but urge caution because:
_____
____ This individual should NOT participate in On-Horse / Riding activities:
_____
____ I recommend this individual NOT participate in the program:

Please specify any other restrictions or limitations you feel are appropriate.
_____
_____

Signature: _____ **Date:** _____