455 Providence Road S. | Waxhaw, NC 28173 | 704.841.0602 | miteyriders.org

Physician's Letter

Date: ______________________________

Dear Health Care Provider:

Your patient, ______________________________[Child's name] is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete 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

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. 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
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 the center at the address/phone indicated above.

Sincerely,
Misty Meadows Mitey Riders

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Warning: Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina General Statutes.

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Annual Physician Prescription for Therapeutic Horseback Riding

NOTE: This section MUST be filled out by your child's General Physician. Mitey Riders may request clearance from an additional medical professional including, but not limited to: PT, OT, Orthopedic Surgeons or others.

Rider Name (First/Middle/Last): ____________________

DOB: ______ / ______ / ______ Age: _________ Height: __________ Weight: _________ lbs. Gender: M / F

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ______________

Prescription for Therapeutic Horseback Riding

This person is NOT medically precluded from participation in equine-assisted activities and therapeutic horseback riding.

Rider Name (First/Middle/Last): ____________________

Diagnosis: ____________________ Date of Onset: ________________

Recommended Frequency ____________________

Precautions (all riders must wear helmets) ____________________

____

Physician Signature:____________________ **Date:**____________________

Physician's Name____________________ MD / DO / NP / PA / Other: _____________

Address: ____________________

Phone: ____________________ License/UPIN Number: ____________________

For patients with Down syndrome:

Therapeutic horseback riding is contraindicated by the Professional Association of Therapeutic Horsemanship International if any of the following conditions are present: neurologic symptoms of atlantoaxial instability (AAI) or positive neurologic clinical signs as evaluated by a physician, significant AAI measurement as determined by a physician, or excessive head/neck instability with or without a helmet.

Physicians: Please verify that this patient has no evidence of AAI and no decrease in neurologic function:

AtlantoDens Interval X-rays, date: ____________________ Result: + / -

Neurologic Symptoms of Atlanto Axial Instability: ____________________

Physician Signature:____________________ **Date:**____________________

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