



Rein in a Dream

Building upon each individual's inner strength!



Medical Authorization for Participation

This form is a requirement of Perkins and PATH Intl. It must be signed by the participants physician and renewed annually.

Participant _____ Date of Birth _____

Weight _____ (max. of 225 lbs.) Height _____ Last Tetanus immunization _____

Gender	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
<input type="checkbox"/> Transmasculine	<input type="checkbox"/> Transfeminine
<input type="checkbox"/> Other Identity	

Ethnicity	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Declined to Specify	

Race	
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> African American
<input type="checkbox"/> Native American	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Asian	<input type="checkbox"/> European
<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Other

HISTORY OF	COMMENTS	HISTORY OF	COMMENTS
Allergy <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Head Injury or <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Epi Pen <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Hernia <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Pregnancy <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Inhaler <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Immunity <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Circulatory <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Cardiac <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Orthopedic <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Bone or Joint <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Neurologic <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Seizures <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Cognitive <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Auditory <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Emotional/ Balance <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Learning <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Speech <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Muscular <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Tactile Sensation <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Visual <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Pain <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Skin <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Bleeding <input type="checkbox"/> Y <input type="checkbox"/> N	_____
Incontinence <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Contagious <input type="checkbox"/> Y <input type="checkbox"/> N	_____
		Ambulatory <input type="checkbox"/> Y <input type="checkbox"/> N	_____

Down Syndrome: Due to the nature of horseback riding, individuals diagnosed with Down Syndrome can only be accepted for riding instruction with a verified negative diagnostic x-ray for Atlantoaxial Dislocation Condition.

My initials here certify that the individual listed on this form has a negative diagnostic x-ray for Atlantoaxial Dislocation Condition. _____

Surgical procedures _____

<i>Please note psychiatric diagnoses or emotional issues</i>	<i>Please note Medications</i>	<i>Please note Restrictions if any</i>

I have examined the person named above and certify, based on that examination and review of the health information contained in this application, that there is no medical evidence which would preclude participation in a Therapeutic Horsemanship/ Riding or Animal Assisted Activity/ Therapy Program (s)

Physician/or Medical Care Provider Printed Name _____

Telephone _____ Address _____

Signature _____ Date _____