



Rein in a Dream

Building upon each individual's inner strength!



Medical Authorization for Participation

This form is active for 1 year.

Participant _____ Date of Birth _____

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

Gender

- Male Female Transmasculine
 Transfeminine Other Identity

Race

- White/Caucasian African American Native American
 Hispanic Asian European Pacific Islander 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>
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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 _____