Rein in a Dream

Building upon each individual's inner strength!

Medical Authorization for Participation

This form is a requirement and must be signed by the participants' physician and renewed annually.

Participant _____ Date of Birth _____

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

Gender	***Ethnicity***	***Race***
☐ Male ☐ Female ☐ Transmasculine ☐ Transfeminine ☐ Other Identity	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify	☐ White/Caucasian ☐ African American ☐ Native American ☐ Hispanic ☐ Asian ☐ European ☐ Pacific Islander ☐ Other

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

Please note psychiatric diagnoses or emotional issues	***Please note Medications***	***Please note Restrictions if any***

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)

PRINT: Physician/Medical Care Provider Name _____

Telephone _____ **Address** _____

PHYSICIAN Signature_____ **STAMP:**

DATE _____

Perkins • 971 Main Street • Lancaster, MA 01523 • 978.365.7376 • perkinsprograms.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International