Application Date: ________________

RIDE WITH PRIDE, INC.

P.O. Box 1203, Staunton, VA 24402-1203

RIDER'S MEDICAL HISTORY and PHYSICIAN'S STATEMENT

Name of Client: ______________________________ Date of Birth: ________________

Address: ____

Parent or Guardian: ______________________________ Phone: ________________

Diagnosis: ____________________________________ Date of Onset: ______________

For persons with Down's Syndrome:

Cervical X-ray for Atlantoaxial Instability: Positive _____ Negative _____ X-ray Date _____

Tetnus Shot: Yes _____ No _____ Date ____________ Height _______ Weight ________

Seizure Type: ________________ Controlled: _______ Date of Last Seizure____________

Medications: ____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation Yes _____ No _____ Braces Yes _____ No _____

Wheelchair Yes _____ No _____ Please indicate any special precautions: ______________

____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Physician name *(please print)* ____

Physician Signature ____

Address ______________________________________ City ____________________

State ________ Zip __________ Phone ______________________ Date ________________