(Office use only) Date Rec'd _________

Medical History and Licensed Health Care Provider Statement

(This form must be completed by a licensed health care professional annually to remain eligible for Morning Star services.)

Patient Name: ____
Date of birth: _______________ Height: __________ Weight: _________

*Primary diagnosis: ____ Date of onset: ____________

*Down Syndrome annual exam for AAI: Positive Negative Exam Date: __________

Seizure(s): Yes No Seizure Type: ____________
Controlled: Yes No Date of last seizure: _________

Shunt present: Yes No Date of last revision: __________
Mobility level: Non-assisted Crutches Braces Walker Wheelchair

Please check to indicate if there are current or past special needs in the following areas. If checked, please explain. (Attach additional pages if necessary.)

Auditory ____

Visual ____

Speech ____

Cardiac ____

Circulatory ____

Pulmonary ____

Neurological ____

Muscular ____

Orthopedic ____

Allergies ____

Digestion ____

Elimination ____

Cognition ____

Emotion ____

Behavior ____

Pain ____

Sensation ____

Is this patient taking any medications which may negatively affect balance, coordination, and/or cognition?

Yes No If Yes, please list medications and effects. (Attach additional page if needed.)

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Precautions and Contraindications

The following conditions, if present, may represent **precautions or contraindications** to equine-assisted activities. **Please check any of these conditions that are present** and explain to what degree. Please be as specific as possible so that we may best evaluate your patient's eligibility for equine-assisted activities, including horseback riding.

ORTHOPEDIC

- Spinal fusion
- Spinal instabilities/abnormalities
- Atlantoaxial instabilities
- Scoliosis >30
- Kyphosis
- Lordosis
- Joint subluxation and dislocation
- Osteoporosis T-score ______ Date of exam ________
- Osteogenesis imperfecta
- Coxa arthrosis
- Pathological fractures

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NEUROLOGICAL

- Hydrocephalus/shunt
- Tethered cord
- Atlantoaxial instabilities
- Spina bifida
- Chiari II malformation
- Hydromyelia
- Cranial deficits
- Paralysis due to spinal cord injury
- Seizure disorder
- Spinal orthoses
- Heterotopic ossification
- Internal spinal stabilization device

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MEDICAL

- Indwelling catheter
- Allergies
- Cancer
- Diabetes
- Peripheral vascular disease
- Hemophilia
- Serious cardiac condition
- Hypertension
- Respiratory compromise
- Fatigue/poor endurance
- Skin breakdown

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PSYCHOLOGICAL/BEHAVIORAL

- Danger to self or others
- Animal abuse
- Substance abuse
- Thought control disorder

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Initial here if none of the above conditions are present: _____

Please indicate any additional precautions or other relevant information regarding this patient's health that should be considered to determine eligibility for equine-assisted activities.

Licensed Health Care Provider Statement

In my opinion, this patient can participate in supervised equine-assisted activities, including horseback riding. I understand Morning Star Riding Center will weigh all medical/psychological information and this statement against any precautions and contraindications presented here. Therefore, I refer this patient to Morning Star Riding Center for final determination of eligibility.

Provider Name/Title (Print): ____

Provider Signature: ____ Date: ___________

License/UPIN Number: ___________________________