P.O. Box 23129
Chagrin Falls, Ohio 44023
Phone: 440-708-0013 / Fax: 440-708-0029
www.fieldstonefarmtrc.com

MEDICAL HISTORY / PHYSICIAN RELEASE

(Physician must complete this form and sign below for all students)

Name: ______________________________ Date of Birth: ____________

Address: ______________________________ Male / Female

Name of Parent / Guardian: ______________________________

Diagnosis: ______________________________ Date of Onset: ____________

Tetanus Shot:: Yes _____ No _____ Date: __________ Height:________ Weight:__________

Seizure Type: ______________ Controlled: ________ Date of last seizure:____________

Medications: ______________________________

Mobility: (Circle each) Ambulatory-Yes/No Crutches-Yes/No Braces-Yes/No Wheelchair-Yes/No

Special precautions: ______________________________

AREAS	HAS Involvement	NO Involvement	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory (incl. hemophilia)			
Pulmonary			
Neurological			
Muscular			
Orthopedic (incl. spinal/ joint abnormal.)			
Allergies (incl. asthma)			
Learning Disability			
Mental Impairment			
Psychological Impair. (incl. behavioral)			
Other (ie: shunt, sensory loss, feeding tube, etc)			

*** * * FOR PERSONS WITH DOWN SYNDROME * * ***

Cervical X-Ray for Atlantoaxial Instability: Positive ____ Negative ____ X-Ray Date ____________
Subsequent annual clinical exam (by physician who is knowledgeable in AAI condition) reveals symptoms of Atlantoaxial Instability?: Yes _____ No _____ Date of Exam ____________

List any other chronic conditions or illnesses not described above: ______________________________

____

Given the above diagnosis and medical information, this person is not medically precluded from participation in mounted therapeutic riding activities. I understand that Fieldstone Farm TRC will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Fieldstone Farm TRC for ongoing evaluation to determine eligibility for participation.

Physician's Signature: ______________________________ DATE: ____________

Physician's Name (**please print**):______________________________ Phone: ____________

Address/City/Zip: ____