Trails End Farm
800 Middle Road
Colchester, Vermont 05446
Phone or Fax: (802) 879-4234
Email: couture879@hotmail.com
Certified Instructor: Jacelynn Couture

Progressive Strides PLC
59 Timber Ridge Road
Underhill, Vermont 05489
Phone: (802) 899-2790
Email: msmcoleman@surfglobal.net
Therapist: Susan Coleman OTR/L

Participant's Medical History & Physician's Statement

Participant Name ____ DOB ______________________

Height ______________________ Weight _________________________

Diagnosis ____ Date of Onset _____________________________

Medications ____

Past/Prospective Surgeries____

Seizures Y N Type ________________ Controlled Y N Date of last seizure ______

Shunt Present Y N Date of last revision ____________________

Tetanus Shot Y N Date of last shot/booster __________

Special Precautions/Needs ____

Wheelchair Y N Independent Ambulation Y N Assisted Ambulation Y N

Braces / Assistive Device ____

Trails End Farm Therapeutic Riding & Progressive Strides Hippotherapy Program are designed to benefit participants physically, socially and emotionally. Safety equipment, specially trained horses and volunteers, and staff are used. In order to assure optimal protection and the greatest personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a rider. ***NOTE: Because of the nature of the activity of horseback riding, individuals with the diagnosis of **Dome Syndrome** cannot be accepted for riding instruction **without proof of a negative diagnosis X-ray for atlanto-axial dislocation condition.**

X-ray Date ________________ Result + -

Neurologic Symptoms of Atlanto Axial Instability ____

Please indicate if impairments exist in any of the following areas by checking Yes or No. If Yes, please comment, use attachments if necessary.

Area	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac/Circulatory			
Immunity			
Pulmonary			
Neurological			
Muscular/Orthopedic/Balance			
Digestion/Elimination			
Learning Disabilities			
Emotional/Behavioral/Mental			
Health			
Allergies			
Cognitive Impairments			
Pain			

Other			

GOALS____
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To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that a NARHA Instructor will weigh the medical information above against exciting precautions and contraindications. I concur with a review of this person's abilities/limitations by licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine program.

Name/ Title ____MD DO NP PA Other_________

Signature ____Date _______________________

Address ____

Phone ( ) ____________________________ License/UPIN Number ___________________________