Jester Park Equestrian Center
Therapeutic Horsemanship Program
Medical Assessment Form

This form is to be completed and signed by the Student's doctor. Date Completed:_____

Student: _____ Age: _____Date of Birth: _____

Address: _____

City:_____ State: ____ Zip:_____ Height: _____ Weight: _____

Diagnosis:_____

Medications (include prescription and over-the-counter): _____

_____

Seizures: Y N If yes, Type of Seizure: _____ Controlled: Y N Last Seizure Date: _____

Shunt present: Y N Date of Last Revision: _____

Special Precautions/Needs: _____

_____

General Attitude and Behavior: _____

_____

Communication Skills: _____

_____

Functional Status: _____

_____

Mobility (circle the one that best describes): Independent Assisted Ambulation Wheelchair

Braces/Assistive Devices: _____

_____

Past/Prospective Surgeries: _____

_____

Allergies: _____

For those with Down Syndrome Atlantoaxial X-ray Information: Date of X-ray_____

Results: ___positive ___negative

Sensory Systems (please indicate current/past needs or any loss in the following areas):

Tactile_____

Proprioceptive_____

Vestibular_____

Visual_____

Auditory_____

Olfactory_____

Weather Sensitivity_____

Postural Control:

Head_____

Trunk_____

Distal_____

Coordination/graded muscle control_____

Postural Insecurity_____

Strength:_____

Perceptual Motor Skills:

Bilateral Coordination_____

Laterality_____

Hand Dominance_____

Body Awareness_____

Motor Planning_____

Visual/Spatial Relationships _____

Gravitational Insecurity_____

Range of Motion (general assessment): _____

Tonus: _____

Alignment: _____

Cognitive Strengths/Needs:_____

_____

Recommendations for the Instructor: _____

_____

Precautions and Contraindications: The following conditions may suggest precautions and/or contraindications to equine activities. Please check those conditions that are present and provide notes on those conditions in the space provided below.

Orthopedic	
Atlantoaxial Instability	
Coxartrosis	
Cranial Defects	
Heterotopic Ossification/ Myositis Ossificans	
Joint subluxation/ dislocation	
Osteroporosis	
Pathologic Fractures	
Spinal Joint Fusion/ Fixation	
Spinal Joint Instability/ Abnomalities	
Neurological	
Hydrocephalus/ Shunt	
Seizure	
Spina Bifida/ Chiari II Malformations/ Tethered Cord/ Hydromyelia	
Other	
Indwelling Catheters/ Medical Equipment	
Poor Endurance	
Skin Breakout	

Medical/ Psychological	
Allergies	
Animal Abuse	
Cardiac Condition	
Physical/ Sexual/ Emotional Abuse	
Blood Pressure Control	
Dangerous to Self or Others	
Exacerbations of Medical Conditions	
Fire Setting	
Hemophilia	
Medical Instability	
Migraines	
PVD	
Respiratory Compromise	
Recent Surgeries	
Substance Abuse	
Thought Control Disorder	
Weigh Control Disorder	

Notes on present conditions from above tables: _____

_____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand the Jester Park Equestrian Center (JPEC) Therapeutic Horsemanship Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the JPEC for ongoing evaluation to determine eligibility for participation.

Name: _____ Title: MD DO NP PA

_____ _____

Signature Date

Address: _____City:_____

State: _____ Zip:_____ Phone: _____