



Positive Strides Therapeutic Riding Center, Inc.

Rider's Medical History and Physician's Statement

Name _____ DOB _____

Address _____

Name of Parent/Guardian/Caregiver _____

Diagnosis(es) _____

Height _____ Weight _____ Date of Tetanus shot _____

Date of Covid-19 Vaccine 1 _____ 2 _____ (must present Covid-19 vaccination card)

For persons with Down Syndrome:

____ Negative Cervical X-ray for Atlantoaxial instability X-ray date _____

____ Negative for clinical symptoms of Atlantoaxial instability

For persons who have seizure disorder

Seizure type _____ Controlled? _____ Date of last seizure _____

Seizure medications _____

Does student use any of the following: Wheelchair _____ Crutches _____ Braces _____

Walker _____ Hearing aid _____ Cochlear implant _____ Other _____

Past surgeries/dates _____

MEDICAL/SURGICAL

Allergies____ Cancer____ Poor endurance____ Recent surgery____ Diabetes____
Peripheral vascular disease____ Varicose veins____ Hemophilia____ Hypertension____
Serious heart condition____ Stroke____

NEUROLOGIC

Hydrocephalus/shunt____ Spina bifida____ Tethered cord____ Chiari II malformation____
Hydromyelia____ Paralysis due to spinal cord injury____ Seizure disorders____

SECONDARY CONCERNS

Behavior challenges____ Age under two years____ Age two to four years____
Acute exacerbation of chronic disorder____ Indwelling catheter____

Please list all medications_____

Drug allergies_____

Physician's printed name_____

Address_____

Phone/email_____

Physician's
signature_____ Date_____