Equine-Assisted Services **Year:_____**
ESMA Equestrian Center

PARTICIPANT'S MEDICAL HISTORY AND MEDICAL PROVIDER STATEMENT

Name:_____Date of Birth: _____

Name of Parent/Guardian:_____

Diagnosis:_____ Date of Onset: _____

Height: _____ Weight: _____ Tetanus Shot: ☐ Yes ☐ No Date:_____

Past/Prospective Surgeries: _____

Medications:_____

Seizure Type:_____ Controlled: YES NO Date of last seizure: _____

Shunt Present: YES NO Date of last revision: _____

****For those with Down Syndrome**:**

Cervical X-ray for Atlantoaxial Instability: Positive_____ Negative_____ X-ray date_____

Neurologic Symptoms of AtlantoAxial Instability:_____

Please indicate any current or past needs in the following systems/areas, including past surgeries:

Special Needs	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

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Mobility: Independent Ambulation ☐ Yes ☐ No Wheelchair: ☐ Yes ☐ No Braces: ☐ Yes ☐ No
Other Adaptive Equipment: _____ Please indicate any special precautions: _____
_____
_____

Check and describe all current therapeutic and safety issues:

- ☐ Inattention _____
- ☐ Hyperactivity_____
- ☐ Lack of concentration _____
- ☐ Learning disabilities _____
- ☐ Developmentally delayed _____
- ☐ Cognitively challenged _____
- ☐ Boundary issues _____
- ☐ Social skills problems _____
- ☐ Problems with peers _____
- ☐ Separation anxiety _____
- ☐ Anxiety _____
- ☐ Phobias _____
- ☐ Aggressive _____
- ☐ Assaultive _____
- ☐ Manipulative _____
- ☐ Unpredictable or dangerous behavior _____
- ☐ Sensory impairment _____
- ☐ Sensitivity/preferences _____
- ☐ Tics or stereotypic behavior _____
- ☐ Psychosomatic symptoms_____
- ☐ Medical issues _____
- ☐ Self-injurious behavior _____

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- ☐ Suicidal ideations

  _____

- ☐ Elopment_____
- ☐ Issues of parental or family support _____
- ☐ Sexual abuse _____
- ☐ Physical abuse _____
- ☐ Emotional abuse _____
- ☐ Hallucinations _____
- ☐ Delusions _____
- ☐ Illusions _____
- ☐ Dissociations _____
- ☐ Substance abuse problems _____
- ☐ Legal problems _____
- ☐ School problems _____
- ☐ Animal abuse _____
- ☐ Fire setting _____
- ☐ Seizure disorder _____
- ☐ Medication side effects_____

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities, including riding. I understand that Easterseals Massachusetts will weigh the medical information given against the existing precautions and contraindications.

Therefore, I refer this person to Easterseals Massachusetts for ongoing evaluation to determine eligibility for participation.

Signature: _____ Date: _____/_____/_____
Name:_____
Title: _____ License/UPIN Number: _____

Address: _____

Phone: _____

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