



## Participant's Medical Clearance and Physician Statement

**To be completed and signed by the  
Participant's Physician**



Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Y N Date of last Seizure: \_\_\_\_\_

Shunt Present: Y N Date of last revision: \_\_\_\_\_

Special precautions/needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

Neurological Symptoms of Atlantoaxial Instability: \_\_\_\_\_ Present \_\_\_\_\_ Absent

**Please indicate current or past special needs in the following system/areas, including surgeries:**

	Y	N
Auditory		
Visual		
Tactile Sensation		
Speech		
Cardiac		
Circulatory		
Integumentary/Skin		
Immunity		
Pulmonary		
Neurological		
Muscular		
Balance		
Orthopedic		
Allergies		
Learning Disability		
Cognitive		
Emotional/Psychological		
Pain		
Other		

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN number: \_\_\_\_\_