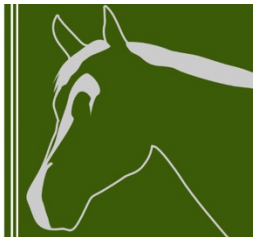
Living Hope Equine Therapy



PHYSICIAN RELEASE FORM

I hereby authorize _____ to release the information from the records
(Physician or medical facility)

of _____. This information is to be released to Living Hope Equine
(Rider's name)
Therapy for the purpose of developing a therapeutic riding program for the above-named client.

SIGNATURE: _____ DATE: _____

Dear Physician: Living Hope Equine Therapy Center offers an equine assisted therapeutic program designed to benefit those with deficits in numerous areas. Safety equipment such as helmets and assistance belts are used and the horses are screened and trained for riders with disabilities. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being considered for the program.

Rider's name: _____ D.O.B.: _____

Name of parent/guardian (for minors) _____

Gender: _____ Height: _____ Weight: _____

Tetanus shot: □ no □ yes Date: _____

Diagnosis: _____ Date of onset: _____

Cause: _____

Medications (type, purpose, dose): _____

_____

_____

Mobility Status:

Ambulatory: □ yes □ no Independent Ambulation: □ yes □ no
Sitting Balance Impaired: □ yes □ no Standing Balance Impaired: □ yes □ no
Crutches: □ yes □ no Braces: □ yes □ no Wheelchair: □ yes □ no

Please indicate any special precautions:

_____

_____

For persons with Down Syndrome:

Negative Cervical X-Ray for Atlantoaxial Instability X-Ray Date: _____

Negative for Clinical Symptoms of Atlantoaxial Instability

For persons with Seizure disorder:

Seizure Type: _____ Controlled: _____

Date of last seizure: _____

For persons with Scoliosis:

Degree: _____ Type: _____

PRECAUTIONS AND CONTRAINDICATIONS INCLUDE (circle all):

Acute MS	Blood pressure control	Osteoporosis (severe)	Spinal fusion
Acute herniated disc	Coxa arthrosis (degeneration of hip)	Osteogenesis imperfecta	Spinal instability
Acute stage of arthritis	Cranial deficits	PVD	Scoliosis greater than 30’
Allergies	Dangerous to self/others	Respiratory compromise	Spondylolisthesis
Animal abuse	Hemophilia	Seizures uncontrolled	Subluxation dislocation of joint
Anti-coagulant medication	Kyphosis (excessive)	Shunt (s)	Substance abuse
Atlanto-axial instability	Lordosis (excessive)	Skin breakdown	Spina bifida unstable spine

Please indicate if patient has a problem or history of problems and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	**YES**	**NO**	**COMMENTS**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning disability			
Mental impairment			
Psychological impairment			
Other			

Precautions:

_____

_____

In my opinion, there is no reason why _____ cannot receive riding therapy under the appropriate supervision.

Physician's Signature _____ Date: _____

Physician's Name: _____
(Please print)

Telephone: _____

Address: _____

_____

Additional Comments:

_____

_____

Please return completed forms in person, by mail, or by email at:

Living Hope Therapy Center
New Participant Registration
408 Hogans Dr.
Trophy Club, TX 76262
tammi.livinghope@outlook.com

WARNING: UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE & REMEDIES CODE) A FARM ANIMAL PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN FARM ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF FARM ANIMAL ACTIVITIES.