PARDS
THERAPEUTIC CENTRE

THERAPEUTIC PHYSICIAN RELEASE

ALL SECTIONS BELOW TO BE COMPLETED BY A PHYSICIAN

Client Name	M___ F___ Preferred Pronoun _____
Primary Diagnosis/Disability	Date of Onset
Secondary Diagnosis/Disability	Date of Onset
Height _____ Weight _____	Date of Birth (M/D/Y)

PLEASE INDICATE IF CLIENT HAS/HAD ANY ISSUES, AND/OR SURGERIES IN ANY OF THE FOLLOWING AREAS BY CHECKING YES. IF YES, PLEASE COMMENT OR INDICATE IF AND WHERE APPLICABLE

AREA	YES	COMMENT
Epileptic		Type:_____ Last Seizure:_____ Frequency:_____ Controlled: Yes or No
Down Syndrome		Cervical X-ray for Atlantoaxial Instability: Positive or Negative Date of X-ray: _____
Diabetic		Insulin:
Emotional Regulation		Stimming_____ Withdrawal _____ Sorrow/Tears _____ Anger_____ Violent Tendencies _____
Cognitive Impairment		Mild _____ Moderate _____ Severe _____
Learning Impairment		Mild _____ Moderate _____ Severe _____
Hearing Impairment		Mild _____ Moderate _____ Severe _____ Hearing Aid _____ Cochlear Implant _____
Vision Impairment		Mild _____ Moderate _____ Severe _____ Glasses _____
Speech Impairment		Mild _____ Moderate _____ Severe _____
Muscular Weakness		Mild _____ Moderate _____ Severe _____
Coordination Issues		Mild _____ Moderate _____ Severe _____
Circulatory Issues		Mild _____ Moderate _____ Severe _____
Cardiac Issues		Mild _____ Moderate _____ Severe _____
Pulmonary Issues		Mild _____ Moderate _____ Severe _____
Orthopedic Issues		Mild _____ Moderate _____ Severe _____ Scoliosis: Degree of _____
Chronic Pain		Mild _____ Moderate _____ Severe _____
Brittle Bones		Mild _____ Moderate _____ Severe _____
Reduced Stamina		Mild _____ Moderate _____ Severe _____
Spasticity		Mild _____ Moderate _____ Severe _____
Mobility Aids		Prothesis / Wheelchair / Walker / Crutch / Leg Brace / Wrist Brace / Other _____
Appliances		(ex. Harrington Rod)
Allergies		
Medication		

ANY FURTHER INFORMATION PLEASE ADD ADDITIONAL SHEET

In my opinion, this Patient can participate in supervised equestrian activities.

Medical Review Recommended In: Less than 1 yr _____ 1 Yr _____ 2 Yrs _____ 3 Yrs _____ 4 Yrs _____ 5 Yrs _____ (max)

Physician Name / Stamp: _____ Signature:_____

Address: _____ Phone: _____

Date: _____

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