



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		ASD ___ FASD ___ Global Delay ___ Other _____ Mild ___ Moderate ___ Severe ___
Behavioral Impairment		ADHD ___ ODD ___ OCD ___ Other _____ Mild ___ Moderate ___ Severe ___
Emotional Disability		Depression ___ Anxiety ___ PTSD ___ Bipolar ___ Other _____
Hearing Impairment		Mild ___ Moderate ___ Severe ___ Hearing Aid ___ Cochlear Implant ___
Vision Impairment		Mild ___ Moderate ___ Severe ___ Glasses ___
Speech Impairment		Expressive ___ Receptive ___ Other _____ Mild ___ Moderate ___ Severe ___
Muscular Weakness		Mild ___ Moderate ___ Severe ___
Coordination Issues		Describe _____ Mild ___ Moderate ___ Severe ___
Circulatory Issues		Describe _____ Mild ___ Moderate ___ Severe ___
Cardiac Issues		Describe _____ Mild ___ Moderate ___ Severe ___
Pulmonary Issues		Describe _____ Mild ___ Moderate ___ Severe ___
Orthopedic Issues		Scoliosis ___ Degree of ___ Other _____ Mild ___ Moderate ___ Severe ___
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, / shunt) Other _____
Allergies/Medications		

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: _____