

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

Dear Health Care Provider:

Your patient, \_\_\_\_\_  
*Participant's name*

is interested in participating in supervised equine activities.

In order to safely provide this service, Walk On requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

AtlantoAxial Instability (include neurologic symptoms)  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint Subluxation/Dislocation  
Osteoporosis  
    Pathologic Fractures  
Spinal Joint Fusion/Fixation  
Spinal Joint Instability/Abnormalities

**Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered  
    Cord/Hydromelia

**Others**

Age – under 4 years  
Indwelling Catheters/Medical Equipment  
Medications – i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

**Medical/Psychological**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self and/or others  
    Exacerbations of medical conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Walk On at the address/phone indicated above.

Sincerely,

Mary Illing, OTR/L

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Mailing Address:

P.O. 376  
Barrington, IL 60011  
WalkOnFarm@comcast.net

Office (847) 381-4231  
Barn (847) 842-8349  
Fax (847) 381-4288

Barn Address:

26665 West Cuba Rd  
Barrington, IL 60010  
WalkOnFarm.org



Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State Zip Code: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 Past/Prospective Surgeries: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Seizure Type: \_\_\_\_\_ Controlled: Y or N Date of last Seizure----: \_\_\_\_\_  
 Shunt Present: Y or N Date of last Revision: \_\_\_\_\_  
 Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation: Y or N Assisted Ambulation: Y or N Wheelchair: Y or N  
 Braces/Splints/Orthotics, Assistive Devices: \_\_\_\_\_  
For those with Down Syndrome: AtlantoDens Interval X-Rays, Date: \_\_\_\_\_ Result: + or --  
 Neurologic Symptoms or AtlantoAxial Instability: \_\_\_\_\_

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

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Walk On will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Walk On for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 License / UPIN Number: \_\_\_\_\_