PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Walk On
Equine Assisted Activities

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 Arthosis
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

**P.O. Box 376 • Barrington, IL 60011-0376 • www.walkonfarm.org**
Phone-Office: (847) 381-4231 • Phone-Barn: (847) 842-8349 • Fax: (847) 381-4288 • Email: walkon@walkonfarm.org
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# Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
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: _____

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