INSTRUCTIONS FOR COMPLETING PHYSICIAN'S LETTER FORM

Download the form and take it to your physician or you can ask your physician to download it and fill it out. Once the form is completed, either mail the form to Eagles' Wings Stable 5730 N. Washington Road, Piqua, OH 45356 or email us at info@eagleswingsstable.org to arrange for a visit to personally deliver the form along with the Student Application and get a tour of our facility. Please do not email the form to us as it would violate HIPAA requirements.

Eagles' Wings Stable, Inc.

Therapeutic Riding Center

A 501 (c)(3) Public Charity

PHYSICIAN'S LETTER

Date:_____

Dear Health Care Provider:

Your patient,_____, is interested in participating in supervised equine assisted activities.

In order to safely provide this service, our center requests that you complete the attached Medical History and Physicians Statement Form. Please note the following conditions may suggest precautions and contraindications to equine assisted activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability—including neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/ Myositis Ossification
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/ Hydromyelia

Other
Under 4 Years of Age
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 Disorder
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgery
Substance Abuse
Thought Control Disorder
Weight Control Disorder

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 the center by calling 937-570-5709.

Sincerely,
Eagles' Wings Stable, Inc.
Therapeutic Riding & Equine Assisted Activity Center

PHYSICIAN'S STATEMENT

Participant's Name:_____ Date:_____
DOB:_____Age:_____Height:_____Weight:_____Gender:_____
Address:_____ City, State, Zip: _____
Diagnosis:_____ Date of Onset: _____
Past/ Prospective Surgeries: _____
Medications:_____
Seizure Type:_____Controlled? Yes ____/ No ____Date of Last Seizure: _____
Shunt Present? Yes ____/ No ____Date of Revision: _____
Special Precautions/ Needs: _____
_____
Mobility: Independent Ambulation? Yes____/ No____ Assisted Ambulation? Yes____/ No ____
Wheelchair -Y/N: _____ Braces or Assistive Devises: _____
For Those With Down Syndrome: AtlantoDens Interval X-Rays—Date:_____Result +/ -: _____
Neurologic Symptoms of AtlantoAxial Instability: _____

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

	YES	NO	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 the CHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the CHA center for ongoing evaluation to determine eligibility for participation.

Physician's Name & Title: _____ License/ UPIN #: _____
Signature:_____ Date:_____
Address:_____ City, State, Zip: _____ Phone: _____