Lethbridge Therapeutic Riding Association

24 205015 Hwy 512, Lethbridge County, AB T1J 5N8
Telephone: (403) 328-2165 Fax: (403) 317-0235

MEDICAL FORMS – MUST BE FILLED OUT

To be completed by the riding applicant's attending physician for therapeutic riding and at least every three years after that or more frequently if there has been a change in the rider's medical condition. This information helps select the rider's horse and number of volunteers needed to make riding safe. All of this information is treated with the utmost care and regard to privacy and protecting the rider's identity. Part A and Part B MUST BE SIGNED BY PHYSICIAN IN ORDER TO RIDE.

Part A:

Rider Name: _____

Date of Birth: _____

Health Care Number: _____

Medical History

Primary Diagnosis: _____

Secondary Diagnosis: _____

Height _____ Weight_____ (cannot exceed 79 kg - 175lbs)

Sex _____

Frequency of Seizures: _____

Medications: _____

For: _____

Please use separate page to detail surgery if needed.

Surgery	**Dates:**
_____	_____
_____	_____
_____	_____

Part B: To be completed by physician

Can the individual walk: Yes: _____ No: _____

Do they walk with: Lots of help: _____ Little help: _____ No help: _____

Does the individual use a wheelchair: Yes: _____ No: _____

Does the individual have a weaker side: Yes: _____ No: _____
Right: _____ Left: _____

Muscle Tone

Tone in upper extremities:	Poor: _____	Good: _____	Excellent: _____
Tone in lower extremities:	Poor: _____	Good: _____	Excellent: _____
Tone in trunk:	Poor: _____	Good: _____	Excellent: _____
Balance sitting:	Poor: _____	Good: _____	Excellent: _____
Standing:	Poor: _____	Good: _____	Excellent: _____
Sensory Function:	Sight: _____	Hearing: _____	Tactile: _____

Continence: _____

Allergies: _____

ATLANTO-AXIAL X-RAY VERIFICATION FOR RIDERS WITH DOWN SYNDROME

Date of X-Ray: _____ Result of X-Ray: _____

Note: *Due to the nature of this activity, persons diagnosed with Down syndrome cannot be accepted for riding instruction without proof of a negative diagnostic x-Ray for atlanto-axial instability. This form must be accompanied by a signed and dated statement from a qualified physician giving the date and result of the diagnostic X-Ray.*

Please list any precautions (i.e. stretching certain body parts)

_____

_____

Medical Review Recommended in: 1 yr____ 2 yrs____ 5 yrs___ other_____

Physician Signature: _____

Date: _____

Physician Printed Name: _____

(Please Print Clearly)

Clinic Address: _____

(Please Print Clearly)

Telephone: _____ Fax: _____