



58800 East 360 Road  
 Jay, Oklahoma 74346  
 (918) 786-2788  
[www.equispiritriding.com](http://www.equispiritriding.com)

**Physician Information**

The following conditions, if present, may represent precautions and contraindications to therapeutic horse riding. Please be sure to clearly identify if any of the following conditions are present and to what degree.

<b><u>Orthopedic</u></b>	<b>Yes</b>	<b>No</b>	<b><u>Medical/ Surgical</u></b>	<b>Yes</b>	<b>No</b>
Spinal Fusion			Allergies		
Spinal Instabilities/ Abnormalities			Cancer		
Atlantoaxial Instabilities			Poor Endurance		
Scoliosis			Recent Surgery		
Kyphosis			Diabetes		
Lordosis			Peripheral Vascular Disease		
Hip Subluxation and Dislocation			Varicose Veins		
Osteoporosis			Hemophilia		
Pathologic Fractures			Hypertension		
Coxas Arthrosis			Serious Heart Condition		
Heterotopic Ossification			Stroke (Cerebrovascular Accident)		
Osteogenesis Imperfecta			<b><u>Muscular</u></b>		
Cranial Deficits			Hypotonic		
Spinal Orthoses			Hypertonic		
Internal Spinal Stabilization Devices			Trunk Control, Upper/Lower extremity, please specify		
Fractures			<b><u>Neurologic</u></b>		
			Seizure disorders		
<b><u>Secondary Concerns</u></b>			Hydrocephalus/shunt		
Behavior problems			Spina Bifida		
Age under two years			Tethered Cord		
Age two - four years			Chiari II Malformation		
Acute exacerbation of chronic disorder			Hydromyelia		
Indwelling catheter			Paralysis due to Spinal Cord injury		

**\*\*If student has Down Syndrome, an additional Atlantoaxial Dislocation X-ray form is required.\*\***

If yes was checked for Scoliosis, Kyphosis, Lordosis, Please List the Degree and the date of last X-Ray Below

Scoliosis: Degree \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Kyphosis: Degree \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Lordosis: Degree \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Further comments / Notes:

**Physician Verification – Please PRINT your name, sign & date –**  
**THANKYOU**

**In my opinion there is no reason why this person cannot participate in supervised equestrian activities.**

Rider's Name:

Physician's Printed Name:

Physician's Signature:

Date:

Phone:

Address: