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Jay, Oklahoma 74346



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www.equispiritriding.com

Rider's Medical History and Physician's Release – Must be completed by Physician

First Name: _____ Last Name: _____

Address: _____

Name of Parent / Guardian: _____

Date of Birth: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Tetanus shot: Yes: _____ No: _____

Seizure Type: _____ Controlled: Date of last seizure: _____

Medications:

Any contagious diseases:

Please indicate if a patient has a problem and/or surgeries in any of the following areas. If yes, please comment, using the back of the form if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Incontinence			
Coordination			
Balance			

Mobility

Independent Ambulation: Yes _____ No _____ Crutches: Yes _____ No _____
Wheelchair: Yes _____ No _____ Braces: Yes _____ No _____