WILLOW CREEK RANCH, INC.
Therapeutic Riding Center

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Ensuring excellence and changing lives through equine-assisted activities and therapies

Dear Healthcare Provider:

Your patient, _____ DOB: _____
(Participant's Name)

is interested in participating in supervised equine-assisted activities and therapies (EAAT) at Willow Creek Ranch.

In order to safely provide this service, our center requests that you complete/update the attached Participant Medical History 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
Coxarthrosis
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 Bilfida

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications –e.g. Photosensitivity
Poor Endurance
Skin Breakdown
Heat/Cold Tolerance

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of medical conditions (e.g. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
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 me directly by phone at 414-791-2509.

Sincerely,

Jennifer Pape, WCR Founder
PATH Intl. Certified Therapeutic Riding Instructor

Return Participant Medical History form or scan forms to wcrvolunteercoordinator@mail.com.

Willow Creek Ranch
7404 Northwest Hwy 83
Mukwonago, WI 53149

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Participant Medical History
To Be Completed by Your Physician

Participant Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past Surgeries/Hospitalizations: _____

Seizure Type: _____ Controlled: □ Yes □ No Date of Last Seizure: _____

Shunt Present: □ Yes □ No Date of Last Revision: _____ Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation: □ Yes □ No Assisted Ambulation: □ Yes □ No Wheelchair: □ Yes □ No

Braces/Assistive Devices: _____

For those with Down Syndrome: Neurologic symptoms of Atlantoaxial Instability: □ Present □ Absent

Please indicate current or past special needs in the following systems/areas including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Yes	**No**	**Comments**
Allergies			
Balance			
Behavioral			
Breathing			
Circulatory			
Cognitive/Thinking			
Digestion			
Emotional/Psychological			
Hearing			
Heart			
Immunity			
Learning Disability			
Muscular			
Neurologic			
Orthopedic			
Pain			
Skin Condition			
Speech			
Tactile Sensation			
Visual			
Other			

Other information you would like to share (e.g. medications):

_____

_____

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Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine-assisted activities and therapies (EAAT). I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Print Name/Title: _____ MD DO NP PA Other:_____

Signature: _____ Date: _____

Address: _____

Phone: _____

License/UPIN Number:_____License Expiration: _____