

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Address: _____

Phone: _____ License/UPIN Number: _____

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
 Coxa Arthrosis
 Cranial Deficits
 Heterotopic Ossification/Myositis Ossificans
 Joint subluxation/dislocation
 Osteoporosis
 Pathologic Fractures
 Spinal Joint Fusion/Fixation
 Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
 Sensory Deficit
 Seizure
 Spina Bifida/Chiari H malformation/Tethered Cord/Hydromyelia

Other

Age - under 4 years
 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 Control
 Dangerous to self or others
 Exacerbations of medical conditions (i.e. RA, MS)
 Fire Settings
 Hemophilia
 Medical Instability
 Migraines
 PVD
 Respiratory Compromise
 Recent Surgeries
 Substance Abuse
 Thought Control Disorders
 Weight Control Disorder

