



**MEDICAL HISTORY/RELEASE
FAITH EQUESTRIAN THERAPEUTIC CENTER**

Participant Name _____ Date of Birth _____

Health Issue(s) _____ Weight _____

Diagnosis, if applicable _____ Date of Onset _____

****FOR PERSONS WITH DOWN SYNDROME:
Cervical x-ray for Atlanto-axial instability: Date _____ positive _____ negative _____**

Tetanus Immunization: Date _____ Seizures: ___no ___yes: Type/describe _____

Medications _____ Allergies _____

Past surgery _____

Mobility: Independent ambulation Crutches Braces Wheelchair Other _____

<u>AREA</u>	<u>DESCRIPTION</u>	<u>or</u>	<u>NONE</u>
Hearing	_____		_____
Vision	_____		_____
Speech	_____		_____
Cardiac/Circulatory	_____		_____
Respiratory	_____		_____
Neurological	_____		_____
Balance/Coordination	_____		_____
Orthopedic	_____		_____
Cognitive/Learning	_____		_____
Behavioral/Emotional/Social	_____		_____
Other	_____		_____
Please indicate any special precautions _____			

Parent/Guardian Signature _____ Date _____

Those with disabilities or current health issues are requested to have a health care provider complete the following:

FOR HEALTH CARE PROVIDER:

Given the above information, this person is not medically precluded from participating in supervised equestrian activities at Faith Equestrian Therapeutic Center.

Signature _____ MD PA NP Other Date _____ *(Please attach prescription for Physical, Occupational, or Speech Therapy if applying for Hippotherapy services)*

Name(Print) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Comments _____

Thank you for your assistance with this application.

PLEASE RETURN TO:
Faith Equestrian Therapeutic Center /Horses for Heroes program
243 Appaloosa Way, Guyton GA. 31312 - 912-728-3728 / 912-655-1480