BEARCAT THERAPEUTIC RIDING AT LANDER UNIVERSITY EQUESTRIAN CENTER

Lander University Equestrian

Dear Rider, Parent or Guardian:

In order to safely provide this service, Bearcat Therapeutic Riding requests that you complete/update the attached Health History annually. 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 Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures

Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II 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

Thank you very much for your assistance. If you have any questions or concerns regarding this rider's participation in equine assisted activities/therapies, please feel free to contact Bearcat Therapeutic Riding at the phone/e-mail indicated below.

Sincerely,

Sandy Garron
Manager of Equestrian Operations
(864) 388-8590
sgarron@lander.edu

BEARCAT THERAPEUTIC RIDING AT LUEC
Health History
(To be completed annually by participant or legal guardian)

Lander University Equestrian

GENERAL INFORMATION

Participant: _____Height: _____ Weight: _____ Gender: M F
Employer/School: _____
Address: _____
Phone: _____
Parent/ Guardian: _____
Address (if different from above): _____
Home Phone: _____Cell: _____Work:_____
E-Mail:_____

HEALTH HISTORY

Diagnosis: _____Date of Onset: _____
Seizure Type: _____Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs:
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:
_____
Medications (include prescription, over-the-counter & note any side effects due to heat, etc.) ___
_____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

To my knowledge there is no reason why I/this person cannot participate in supervised equestrian activities/therapies. However, I understand that the Bearcat Therapeutic Riding will weigh the medical information above against the existing precautions and contraindications to determine whether I/this person shall be eligible to participate in Equine Activities/Therapies at Bearcat Therapeutic Riding. I concur with a review of this person's abilities by the staff of Bearcat Therapeutic Riding in the implementing of an effective equestrian program.

Participant/Legal Guardian Name (PleasePrint):_____Relationship_____
Signature: _____ Date: _____
Address:_____
Phone: ( ) _____