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**Cochise Area Network of Therapeutic Equestrian Resources**  
**PO Box 1316, Sierra Vista, AZ 85636**  
**(520) 378-3196**

Date: \_\_\_\_\_

Health Care Provider:

Your patient \_\_\_\_\_ is interested in participating in supervised equine activities.  
(Participants name)

In order to safely provide this service, our center requires that you complete/update the attached medical history and Physician's Statement 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  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis  
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 patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated.

7388 East Chief Joseph Drive - Sierra Vista, AZ - 85635  
Phone:(520) 378-3196 - Email: [info@canteraz.org](mailto:info@canteraz.org)

## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

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

*For those with Downs Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + \_\_\_\_\_ - \_\_\_\_\_

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

***Please indicate current or past special needs in the following systems/areas, including surgeries***

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the Cochise Area Network of Therapeutic Equestrian Resources (CANTER) PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the CANTER PATH center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_