Jake E's Riding Round Up

RIDER'S MEDICAL HISTORY AND PHYSICIAN STATEMENT

Rider's Name _____ Birth Date _____ Age _____

Address _____ Height _____ Weight _____

Diagnosis _____ Date of Onset _____

Medications and Dosage _____

_____

Shunt: Present _____ Date of last revision _____

Tetanus Shot: Yes _____ No _____ Date of Shot _____

Seizure: Type _____ Controlled _____ Date of last seizure _____

****For persons with Down Syndrome:**

Cervical x-ray for Atlantoaxial Instability Positive _____ Negative _____ Date of x-ray _____

Before being accepted as a rider, it is essential that the questions are thoroughly and completely answered, so that each rider's abilities and limitations are given due consideration by Jake E's Riding Round Up's trained instructor's, the student's physician and therapist. **PLEASE SEE REVERSE SIDE OF THIS PAGE.**

Special Precautions _____

_____

Specific body movements or positions NOT to be attempted _____

Specific body movements or positions desired _____

TO THE PHYSICIAN: Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please provide a comment. Please sign document on reverse side.

Areas	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Mental Improvement			
Psychological Impairment			
Pain			
Other			