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Date: _____

Dear Health Care Provider:

Your patient, _____
(Participant's Name)

is interested in participating in a supervised equine activities program at "Stirrup Some Fun", a therapeutic riding program operating under the umbrella of the Statesboro-Bulloch County Parks and Recreation Department.

In order to safely provide this service, our center requests that you complete/update the attached 'Participant's 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 Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurological

Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/Chiari II malformation/Tethered
Cord/Dyromyelia

Other

Age – under 4 years
Skin Breakdown
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 me at the email address or telephone number indicated above.

Sincerely,

Alison A Brown

Alison Brown,
Stirrup Some Fun (SSF) Program Contract & the SSF Advisory Committee



www.bullochrec.com



Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Age: _____ Height: _____ Weight: _____
 Address: _____
 Phone: _____ Email: _____ Alternative #: _____
 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
 Braces Adaptive Devices: _____
 For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --
 Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/area, including surgeries:

| | Y | N | Comments |
|-------------------------|---|---|----------|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Communication/Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Digestion | | | |
| Elimination | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Bone/Joint | | | |
| Balance | | | |
| Orthopedic | | | |
| Behavioral | | | |
| Pain | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Other | | | |

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the "Stirrup Some Fun" Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the "Stirrup Some Fun" Program for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____
 Signature: _____ Date: _____
 Address: _____
 Phone: () _____ License/UPIN Number: _____