EQUUSTRONG UK PARTICIPANT'S MEDICAL HISTORY AND DOCTOR'S STATEMENT

Participant: _____ DOB: _____

Height: _____ Weight: _____

Address: _____

_____

Diagnosis:

_____

Date of Onset: _____

Past / Prospective Surgeries: _____

Medications: _____

Seizure Type (if applicable): _____
Controlled: **Y / N**

Date of last seizure (if applicable): _____

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 (if applicable): _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile			
Speech			

Cardiac			
Circulatory			
Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional / Psychological			
Pain			
Other			

Please provide additional details on a separate sheet if necessary.

Given the above diagnosis and medical information, this person is / is not (please delete as appropriate) medically precluded from participation in equine assisted activities. I understand that if this person is not medically precluded from participation in equine assisted activities the Equustrong UK will weigh the medical information given against the existing precautions and contraindications.

Name: _____

GMC Number: _____

Signature: _____

DATE: _____

Address:

_____

_____

Post Code: _____

Phone: _____

E-mail: _____