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): ___
Braces/Assistive Devices: _____
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 NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

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

NARHA Standards & Accreditation Manual 2005

MEDICATIONS ***(include prescription, over-the-counter: name, dose and frequency)***

_____
_____
_____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)

PHYSICAL FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____
_____

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____
_____
_____
_____
_____
_____

GOALS ***(i.e. Why are you applying for participation? What would you like to accomplish?)***

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

PHOTO RELEASE (I DO / I DO NOT)

_____ consent to and authorize the use and reproduction by DREAM ON CURLS CENTER of any and all photographs and any other audio/visual materials taken of me (_____) for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian - signed in the presence of center staff