Administrative Office P. O. Box 924067 Houston, TX 77292
281-356-7588 Fax 1-866-495-1351
SIRE Fort Bend 7206 Poolhill Rd Fulshear, TX 77441
SIRE Spring 4610 Sloangate Dr Spring, TX 77373

SIRE is a Premier Accredited Center through the
Professional Association of Therapeutic Horsemanship International (PATH INTL)

Clients' Medical History and Physician's Statement

Must be signed by Physician and Client/Parent/Guardian

Client Name: _______________________________ M/F: ____ Date of Birth: ____________ Height: ________ Weight: ________

Diagnosis: ____ Date of Onset: _______________

Seizure Type: ____ Controlled: _________ Date of last seizure: _________________

Medications: ____

Shunt Present: Yes No Date of last shunt revision: __________________________

Past/Prospective surgeries: ____

Please indicate if patient has a problem and/or surgeries in the following areas by checking Yes or No. If yes, please comment.

Mobility: Independent Ambulation ___ Yes ___ No, Crutches ___ Yes ___ No, Braces ___ Yes ___ No, Wheelchair ___Yes ___ No

Areas	Yes	No	Comments
Behavioral			
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning			
Psychological			
Other			

Client/Parent/Guardian Signature: ___________________________________ Date:______________

***** PHYSICIAN MUST SIGN AND DATE THIS FORM BELOW*****

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that SIRE will weigh the medical information above against the existing precautions and contraindications. Therefore I refer this person to SIRE for ongoing evaluation to determine eligibility for participation**. I have read the attached Precautions and Contraindications.**

***FOR PERSONS WITH DOWN SYNDROME:

Neurologic symptoms of Atlanto Axial Instability: _____ Present _____ Absent

Please indicate any special precautions: ____

Physician Signature: _____________________________________Date: __________________

Physician Name (please print): ____________________MD, DO, NP, PA, Other: ____________

Address: ____Phone: ____________________

City, ST, Zip: ____

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Precautions & Contraindications

Precautions and Contraindications:
The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please review this information, and if present, contact SIRE for more information.

ORTHOPEDIC
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Osteoporosis
Heterotopic Ossification/Myositis
Joint subluxation/dislocations

NEUROLOGIC
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities
Seizure Disorder
Spina Bifida/Chiari II malformation/Tethered
Cord/Hydromyelia
Hydrocephalus/Shunt

OTHER
Indwelling Catheters
Skin Breakdown
Weight exceeds 200 pounds

MEDICAL/PSYCHOLOGICAL
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Exacerbation's of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders