T.E.A.D. – EQUESTRIAN ASSOCIATION FOR THE DISABLED

RIDER MEDICAL INFORMATION (Please print)

Name: _____ Birth Date: _____

Address: _____ City: _____

Postal Code: _____ Telephone: Day _____ Evening _____

Sex: _____ Age: _____ Height: _____ ****Weight**:** _____
(must be filled in)

PLEASE NOTE WEIGHT LIMIT: 170 POUNDS or 75 KILOGRAMS

Attending school at: _____ City: _____

Next of Kin: _____ Phone #: _____

Involved in ongoing therapy: Yes ( ) No ( ) Where: _____

Physiotherapist's name: _____

MEDICAL

Primary Diagnosis: _____

Secondary Diagnosis: _____

Name and Date of significant operations: _____

_____

Medications: _____ For: _____

Diabetic ( ) Allergies ( ) Fainting ( ) Epileptic ( )

Frequency of seizures: _____ Date of last seizure: _____

Heart Problem ( ) Bladder Problems ( ) Sight Problems ( ) Specify: _____
If Blind, classification, e.g. B1, B2.

_____

Hearing Problems ( ) Specify: _____

Any Behaviour Problems (i.e. biting or hair pulling) ( ) Specify: _____

Tone in upper extremities: _____
Tone in Lower extremities: _____
Tone in Trunk: _____

Spasticity ( ) Specify: _____

Balance sitting: Independent ( ) or Needs assistance ( )
Standing: _____ Walking: _____

Ambulatory: Yes ( ) No ( ) If no, explain(e.g. wheelchair, walker, braces, crutches, etc.)

_____

Co-ordination: Normal ( ) Specific Deficit: _____

Language:	Ability to Understand	Good ( )	Fair ( )	Poor ( )
	Sign Language	Yes ( )	No ( )	
	Verbal Skills	Good ( )	Fair ( )	Poor ( )

To the Medical Doctor:
Are there any exercises that you would recommend for the rider while riding? Please describe.

_____

Are there any exercises this rider SHOULD NOT be doing? Please describe.

_____

ARE THERE ANY KNOWN COMMUNICABLE DISEASES?
Please specify: _____

The undersigned hereby acknowledges that _____
is medically able to participate in the Horse Riding Program offered by T.E.A.D. – Equestrian Association for the Disabled. I concur with the referral of the patient to a volunteer physiotherapist for evaluation of his/her physical abilities and/or limitations, as deemed necessary.

Name of Rider's Doctor: _____ Phone #: _____

Address: _____ City: _____ Postal Code: _____

Signed: Physician: _____

Parent/Guardian/Rider: _____ Date: _____

****For Office Use Only****

Physiotherapists Remarks: _____

_____

Approved: Yes / No Date: _____

Signed: _____ Position: _____

PLEASE ENSURE THAT THESE FORMS HAVE BEEN SIGNED AND WITNESSED IN ALL THE APPROPRIATE AREAS TO ENABLE US TO PROCESS THEM.