## COURAGE KENNY RIDERS MEDICAL HISTORY & PHYSICIAN RELEASE FORM

Address Street City  Diagnosis Date of Name of Parent/Guardian	th	
Diagnosis		
** All text inside this box must be filled out by a phys Height: Weight: Tetanus Shot:	State	Zip
** All text inside this box must be filled out by a phys  Height:	of Onset	
** All text inside this box must be filled out by a phys  Height:		
Height:		
Height:		
Seizure Type:		-
*** FOR PERSONS WITH DOWN SYNDROME:  Cervical X-Ray for Atlantoaxial Instability:		:
Cervical X-Ray for Atlantoaxial Instability:	te of last seizure:	·
Medications:  Please indicate if patient has a problem/and/or surgeries in any of the following areas by please comment:  Areas Yes No Comments  Auditory		
Please indicate if patient has a problem/and/or surgeries in any of the following areas by please comment:  Areas Yes No Comments  Auditory	ıy Date:	
Please comment:  Areas Yes No Comments  Auditory  Visual		
Please comment:  Areas Yes No Comments  Auditory  Visual	ov obcoking "voo	" or "no " If "voc
Areas Yes No Comments  Auditory  Visual  Speech  Cardiac  Circulatory  Pulmonary  Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation  Braces  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjiconcur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)	by checking yes	or no. ii yes
Auditory Visual Speech Cardiac Circulatory Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other Mobility: Independent Ambulation Braces Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuconcur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Visual Speech Sp		
Speech Cardiac Circulatory Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other Mobility: Independent Ambulation Braces Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuctoncur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Cardiac  Circulatory  Pulmonary  Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuctoncur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Circulatory Pulmonary Neurological Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other Mobility: Independent Ambulation Braces Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuconcur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)	-	
Pulmonary Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjucton concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Neurological  Muscular  Orthopedic  Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjucton concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Muscular Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other Mobility: Independent Ambulation Braces Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjucton concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Orthopedic Allergies Learning Disability Mental Impairment Psychological Impairment Other Mobility: Independent Ambulation Braces Braces Hease indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjucton concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Allergies  Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjucton concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Learning Disability  Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation  Braces  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuconcur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Mental Impairment  Psychological Impairment  Other  Mobility: Independent Ambulation Yes No Crutches Braces  Braces  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuconcur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Other		
Other		
Mobility: Independent Ambulation  Yes No Crutches Braces Yes No Wheelchair  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuctorized with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
Braces Yes No Wheelchair  Please indicate any special precautions:  In my opinion, this patient can participate in supervised equestrian activities. In conjuctor concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)		
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In my opinion, this patient can participate in supervised equestrian activities. In conjugate concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)	☐ Yes ☐ N	0
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concur with the referral of the patient to a physical/occupational therapist or other evaluation of his/her abilities/limitations in performing exercise and implementing an Physician Name: (Please Print)	junction with the	se activities, I
Physician Name: (Please Print)	healthcare profe	essional for
	effective equest	rian program.
Physician Signature:		
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A delugação		
Address:Clinic Street City	Ctat	7:5
•	State ::	

Fax completed forms to: (651)-241-3393 Attn: Taylor McLean