# Mephibosheth Farms Angelic Riders

## HEALTH HISTORY

To be completed by independent adult participant or parent/guardian. Use additional sheets if needed.
**Important!** This form is due to Mephibosheth Farm no later than one week prior to the start of initial session.

Participant Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____ Male / Female

Participant is a (circle one): minor adult w/a legal guardian independent adult

Name of Parent(s) / Guardian(s): _____

Diagnosis: _____ Date of Onset: _____

Height: _____ Weight: _____

Mobility: Ambulatory-Yes/No Crutches-Yes/No Braces-Yes/No Wheelchair-Yes/No Walker-Yes/No

Special mobility precautions: _____

## GENERAL QUESTIONS

List any chronic conditions or illnesses: _____

_____

| HEALTH AND FUNCTION | Normal | DETAILS |
|---|---|---|
| Hearing | | |
| Vision | | |
| Speech | | |
| Heart | | |
| Circulation | | |
| Cognitive Development | | |
| Pulmonary | | |
| Neurological | | |
| Muscular | | |
| Orthopedic (incl. spine & joints) | | |
| Emotional & Psychological | | |
| Behavior | | |

List precautions. For example, shunts, feeding tubes, etc.: _____

_____

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## HEALTH HISTORY

1. In the past 12 months, has the participant been hospitalized for any serious injury, condition or surgery?

   Yes / No, If yes, please explain: _____

   _____

2. In the past 12 months, has the participant experienced loss of consciousness, traumatic or otherwise, including seizures of any type? Yes / No If yes, please explain: _____

   _____

3. In the past 12 months, has the participant experienced a psychotic crisis?_____

   _____

   Yes / No If yes, please explain: _____

   _____

4. In the past 12 months, has it been necessary to restrict the participant's activities due to medical reasons?
   Yes / No If yes, please explain: _____

   _____

Has the participant ever been treated for any of the following? **If yes**, check the box, give date and provide specific details below:

| | **CONDITIONS** | **Date** |
|---|---|---|
| ❒ | Bleeding or Clotting Disorders | _____ |
| ❒ | Diabetes | _____ |
| ❒ | Immune Deficiency | _____ |
| ❒ | Fatigue or limited endurance | _____ |
| ❒ | Pathologic fractures | _____ |
| ❒ | Brain injury, including stroke | _____ |
| ❒ | Conditions of the spine, including, but not limited to: spinal cord injury, curvature, fusion, instability, abnormalities or Spinal Bifida | _____ |
| ❒ | Skin break down or pressure sores | _____ |

Specific details. Use additional paper if necessary: _____

_____

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

Signature of Person completing the health history: _____

Relationship to Participant: _____ Date: _____

# PHYSICIAN'S RELEASE

**Important!** This form is required for participants who have medical issues deemed precautions to participating in equine assisted programming.

Participant Name: _____ Date of Birth: _____

**A PHYSICIAN's RELEASE is required if:**

- ❒ Participant has **Down Syndrome**
- ❒ If any of the HEALTH QUESTIONS on page 2, (#'s 1, 2, 3 or 4) are answered YES
- ❒ If participant has been treated for any of the CONDITIONS listed in the HEALTH QUESTIONS on page 2.

**PHYSICIAN'S REPORT**

| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
|---|---|---|
| Eyes/Ears/Nose/Throat | | |
| Lymph Nodes | | |
| Pulses | | |
| Heart | | |
| Lungs | | |
| Abdomen | | |
| Skin | | |
| Neurologic | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Upper Extremities | | |
| Lower Extremities | | |
| **FOR PERSONS WITH DOWN SYNDROME**: | | |
| Neurologic exam reveals symptoms consistent with atlantoaxial instability? YES NO | | |
| DATE OF EXAM: | | |

**PHYSICIAN'S RELEASE**

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Mephibosheth Farms will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Mephibosheth Farms for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ Date: _____

Physician's Name (**please** print): _____

Address/City/Zip: _____

**If participant has experienced seizure activity within the past 12 months, the following SEIZURE EVALUATION FORM is required. Participants or their parents or guardians may wish to consult with their physician when completing the following:**

## SEIZURE EVALUATION FORM

**Instructions:** Participants/parent/guardians/treating physicians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Physician Treating Seizures: _____ Physician's Phone: _____

Type of Seizure (if more than one, please list all types): _____

_____

Date of Last Seizure:_____ Frequency of seizures: _____

Duration of Each Seizure:_____

Typical Causes of Seizure Activity: _____

_____

_____

Seizure activity indicators (aura, behaviors or manifestations of oncoming seizure activity): _____

_____

_____

After Affect:_____

_____

_____

During a seizure, I / my child/patient:

□ May stare briefly (How long?)_____

□ May walk around

□ May perform aimless activities

□ May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color

□ May experience loss of bladder or bowel control

□ May be confused, have a headache, be fatigued; followed by full return of consciousness

□ Other. Please explain: _____

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## SEIZURE EVALUATION FORM

Are you / is your child/patient able to know and express when a seizure may occur? Yes No

What are the signs?_____

_____

Should you / your child experience a seizure while at Mephibosheth Farm, beyond employing general first aid, what actions do you suggest we take?

- ❒ Do nothing
- ❒ Report observations to parents/guardians immediately
- ❒ Dismount from horse
- ❒ Allow ____ minutes to rest and reorient
- ❒ Other. Please specify: _____

Participant/Parent/Guardian _____ Date _____