

## Medical History/Physician Release Please complete this form as thoroughly as possible. For items that are not applicable, please write N/A. Client/patient Name: \_\_\_\_\_ Age \_\_\_\_ Date of Birth:\_\_\_ Check the following areas of concern for this client. If necessary, add another page with details 1.Any allergies to: pollens? medications? insect bites? food? Please list any dietary restrictions: 2. Currently treated for any of the following: asthma epilepsy / seizure disorder Date of last seizure \_\_\_\_\_ heart trouble diabetes frequently upset stomach physical disability cognitive or psychological disorder Diagnosis: \_ \_\_Date of Onset:\_ Please indicate if client has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment. Areas Yes Comments/Date of Surgery Auditory Visual Speech Cardiac Circulatory **Pulmonary** Neurological Muscular Orthopedic Allergies **Learning Disability Mental Impairment Psychological Impairment** Other: Mobility: ( ) Independent Ambulation ( ) Crutches ( ) Braces ( ) Wheelchair Please Indicate Any Special Precautions or Restrictions: 3. Any prescribed or other medications/drugs, that could impair function or ability to participate in any activities? Client/patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ 4. Date of last tetanus shot: 5. Are all immunizations up to date? yes no If no, please explain:

Please list and explain any major illnesses experienced during the last year:



I,	, verify that the information disclosed above is thorough
and accurate.	
Signature	
	Date
Relationship to client:	
Physician's Certification:	
In my opinion this patient can participate in eq	questrian activities. In conjunction with these activities:
	to a physical/occupational therapist or other health care ns in performing exercises and implementing an effective of this patient/client.
There are no special needs or restric	ctions regarding this client/patient.
I certify that I have examined the above individed physical activities, except the following:	dual and I feel this individual may participate in all program and/ or
Name of examining physician (print please)	Date
Signature of examining physician	Date
Address of examining physician (print please)	