CENTAUR STRIDE INC.

## 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 | No | 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:

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

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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 equestrian activities. In conjunction with these activities:

_____ I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program, due to the special needs of this patient/client.

_____ There are no special needs or restrictions regarding this client/patient.

I certify that I have examined the above individual and I feel this individual may participate in all program and/ or physical activities, except the following:

_____

_____

_____

_____ _____
Name of examining physician (print please) Date

_____ _____
Signature of examining physician Date

_____ _____
Address of examining physician (print please) Phone