EQUINE THERAPY ASSOCIATES

www.equinetherapyassociates.com

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This is an update form for your participant's physician. Attach a copy of the previous Participant's Medical History & Physician's Statement.

Date: _____

Dear Health Care Provider:

Your patient _____

(participant's name)

has been participating in supervised equine activities at Equine Therapy Associates

(center)

and is due for an update of his/her medical status. Please review the previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses, hospitalizations, changes in medications, treatment, weight or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the reverse. If this person has Down syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her neurologic exam.

Diagnosis: _____

Height:_____ Weight: _____

Update Status: _____

_____

_____

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Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other _____

Signature:_____ Date: _____

Address: _____

Phone: (___)_____ License/UPIN Number: _____