Cloud Dancers
THERAPEUTIC HORSEMANSHIP

The mission of Cloud Dancers Therapeutic Horsemanship Program, Inc., a non-profit corporation, is to provide equine-assisted activities to individuals with physical, developmental, emotional, and/or social needs through innovative riding, vaulting and ground programs.

Rider's Medical History and Physician's Statement (1/2)

Must be Completed by Rider's Physician

Your patient, _____ is interested in participating in supervised equine activities. To safely provide this service, Cloud Dancers requests that you complete the following medical form. **Please note that the following conditions may suggest precautions and contraindications to equine activities.** Therefore, when completing this form, please note whether these conditions are present, and to what degree.

- ☐ Abuse
- ☐ Allergies
- ☐ Animal Abuse
- ☐ Atlantoaxial Instability - include neurologic symptoms
- ☐ Blood Pressure Control
- ☐ Cardiac Conditions
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ Dangerous to self or others
- ☐ Exacerbations of medical conditions (i.e.RA,MS)
- ☐ Fire Settings
- ☐ Hemophilia
- ☐ Heterotopic Ossification/Myositis Ossificans
- ☐ Hydrocephalus/Shunt
- ☐ Indwelling Catheters
- ☐ Joint subluxation/dislocation
- ☐ Medical Equipment
- ☐ Medical Instability
- ☐ Medical/Psychological
- ☐ Medications (i.e., photosensitivity)
- ☐ Migraines
- ☐ Neurologic
- ☐ Orthopedic
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Physical/Sexual/Emotional
- ☐ Poor Endurance
- ☐ PVD
- ☐ Recent Surgeries
- ☐ Respiratory Compromise
- ☐ Seizure
- ☐ Skin Breakdown
- ☐ Spina Bifica/Chiari II malformation/Tethered Cord/Hydromyelia
- ☐ Spinal Joint Fusion/Fixation
- ☐ Spinal Joint Instability/Abnormalities
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorders
- ☐ Other: _____

Physician Signature: _____ **Date:** _____

CD Staff Initials: _____ Date: _____

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Rider's Medical History and Physician's Statement (2/2)

Must be Completed by Rider's Physician

Rider's Name: _____ **Height**: _____ **Weight**: _____ **Birthdate**: _____ **Gender**: M / F

Diagnosis: _____ **Date of Onset**:_____

Past/Prospective Surgeries: _____

Medications: _____

Psychological: _____

Allergies (To Medications or Other): _____

Date of Tetanus Shot: _____ **Seizure Type**: _____ **Date of Last Seizure**: _____ **Controlled**: Y / N

Shunt Present: Y / N **Date of Last revision**: _____ **Special Precautions/Needs**: _____

Current or Past Special Needs:

☐ Allergies	☐ Circulatory	☐ Immunity	☐ Pulmonary
☐ Auditory	☐ Cognitive	☐ Integumentary/Skin	☐ Spasticity and/or Rigidity
☐ Balance	☐ Communication	☐ Learning Disability	☐ Speech
☐ Behavioral	☐ Coordination	☐ Muscular	☐ Tactile Sensation
☐ Bones/Joint	☐ Digestion	☐ Neurologic	☐ Visual
☐ Breathing	☐ Elimination	☐ Orthopedic	☐ Other:
☐ Cardiac	☐ Emotional/Psychological	☐ Pain	_____

Mobility: Independent Ambulation Y / N **Assisted Ambulation:** Y / N **Wheelchair**: Y / N

Braces/Assistive Devices: _____

NOTE FOR PERSONS WITH DOWN SYNDROME

DUE TO THE NATURE OF HORSEBACK RIDING, INDIVIDUALS DIAGNOSED WITH DOWN SYNDROME CAN ONLY BE ACCEPTED INTO OUR PROGRAM WITH DOCUMENTED NEGATIVE INDICATION FOR ATLANTOAXIAL INSTABILITY. I CERTIFY THAT THE PATIENT NAMED ABOVE RECEIVED A COMPLETE NEUROLOGIC EXAM THAT REVEALS NO EVIDENCE OF ATLANTOAXIAL INSTABILITY OR DECREASE IN NEUROLOGIVAL FUNCTION. Please initial: _____

Given the diagnosis and medical information, this individual is not medically precluded from participation in equine assisted activities. I understand that Cloud Dancers will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this individual to Cloud Dancers for ongoing evaluation to determine eligibility for participation. In my opinion the above patient can participate in equine assisted activities for a duration of 45 – 60 minutes under appropriate supervision.

Physician Name/Title (Print): _____ **MD DO NP PA Other:**_____ **Date**:_____

Physician Signature: _____**License/UPI Number:** _____ **Phone:** _____

Physician's Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact Cloud Dancers at programs.clouddancersthp@gmail.com, P.O. Box 10489 Albuquerque NM 87184 or leave a message at 505-926-1426.

CD Staff Initials: _____ Date: _____