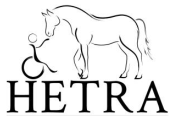

Heartland Equine Therapeutic Riding Academy
10130 S. 222nd Street, Gretna, NE 68028 | 402-359-8830 | www.HETRA.org

PRECAUTIONS & CONTRAINDICATIONS FORM

Dear ______________________________,

Your patient,______________________________ is interested in participating or continued participation in supervised equine activities at our facility. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions, if present may represent precautions or contraindications to equine activities.
Therefore, when completing this form, please circle any conditions that are present, and explain below to what degree.

ORTHOPEDIC

- ☐ Spinal Joint Fusion/Fixation
- ☐ Spinal Joint Instabilities/Abnormalities
- ☐ Atlantoaxial Instabilities (including neurological symptoms)
- ☐ Heterotopic Ossification/Myositis Ossificans
- ☐ Joint Subluxation and Dislocation
- ☐ Osteoporosis – T-Score ______ Date of exam __________
- ☐ Pathologic Fractures
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ History of Joint Replacement
- ☐ Scoliosis/Kyphosis/Lordosis
- ☐ Herniated/Slipped Disc

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NEUROLOGIC

- ☐ Hydrocephalus/shunt
- ☐ Spina Bifida
- ☐ Chiari II Malformation
- ☐ Hydromyelia
- ☐ Seizure Disorders
- ☐ Tethered Cord

____

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____

____

MEDICAL/PSYCHOLOGICAL

- ☐ Allergies
- ☐ Animal Abuse
- ☐ Cardiac Condition
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Blood Pressure Control
- ☐ Dangerous to self or others
- ☐ Exacerbations of medical conditions (ie RA, MS)
- ☐ Hemophilia
- ☐ Fire Settings
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Respiratory Compromise
- ☐ Recent Surgeries
- ☐ Substance Abuse
- ☐ Thought Control Disorders
- ☐ Weight Control Disorders

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OTHER

- ☐ Indwelling Catheter/Medical Equipment
- ☐ Age under 4 years
- ☐ Medications - ie photosensitivity
- ☐ Poor Endurance
- ☐ Skin Breakdown
- ☐ Poor Head & Neck Control
- ☐ Fatigue/Poor Endurance

____

____

Initial here if none of these conditions are present:_______

Treating Physician Signature____Date________________________________

Treating Physician Name (please print)____

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact me at 402-359-8830.

Heartland Equine Therapeutic Riding Academy
HETRA PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name____________________________________ Date of Birth_________________Height____________Weight__________

Address____ Name of Parent/Guardian__________________________________

Parent/Guardian Phone: __________________________ Parent/Guardian Email:_____________________________________

Diagnosis____ Date of Onset____________________________

Past/FutureSurgeries____Medications:______________________________

***For Persons with Down Syndrome: ☐ Negative Cervical X-ray for atlantoaxial instability- X-ray date___________
☐ Negative for clinical symptoms of atlantoaxial instability

Seizure Type_____________________________________ Controlled ☐ Yes ☐ No Date of last seizure_________________

Shunt Present: ☐ Yes ☐ No Date of Last Revision:______________ Tetanus Shot ☐ Yes ☐ No Date of last Tetanus______

Please indicate current or past special needs in the following areas by checking yes or no. If yes, please comment.

AREAS	Yes	No	Comments
Auditory (hearing)	____	____	______________________________
Visual	____	____	______________________________
Speech (communication)	____	____	______________________________
Cardiac	____	____	______________________________
Circulatory	____	____	______________________________
Pulmonary	____	____	______________________________
Neurological	____	____	______________________________
Muscular	____	____	______________________________
Orthopedic (Bone/Joint)	____	____	______________________________
Allergies (including medication)	____	____	______________________________
Thinking/Cognitive	____	____	______________________________
Emotional/Mental Health	____	____	______________________________
Behavioral	____	____	______________________________
Digestion	____	____	______________________________
Elimination	____	____	______________________________
Pain	____	____	______________________________
Sensation	____	____	______________________________

Mobility Independent Ambulation_____ Crutches_____ Braces_____ Wheelchair_____ Walker_____

Please indicate any special precautions/additional information____

____

In my opinion, this person can participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review/screening of the person's abilities/limitations by a licensed/credentialed health professional (PT, OT, or Speech) in the implementing of an effective equestrian program.

Treating Physician Name (please print)______________________________________Phone________________________

Treating Physician Signature____Date__________________________

Address_______________________________________City_____________State___________Zip ______________________