



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

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

NEUROLOGIC

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

OTHER

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

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.



Name _____ Date of Birth _____ Height _____ Weight _____

Address _____ Name of Parent/Guardian _____

Diagnosis _____ Date of Onset _____

Past/Future Surgeries _____ 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 _____