Hope Springs Equestrian Therapy, Inc.
P. O. Box 156, Chester Springs, PA 19425
(610) 827-0931

SUMMARY OF STUDENT'S MEDICAL HISTORY
(TO BE COMPLETED BY STUDENT'S ATTENDING PHYSICIAN)

Name of Studentr: _____ Birth Date:_____
Address: _____ Sex: _____
_____ Height: _____
Telephone: _____ Weight: _____

Check whichever of the following applies: **List medications, dosage, and time taken:**

Physically Disabled:	Yes: ___	No:___	Name:_____	Dosage:_____	Time:___
Mentally Disabled:	Yes: ___	No:___	Name:_____	Dosage:_____	Time:___
Learning Disabled:	Yes: ___	No:___	Name:_____	Dosage:_____	Time:___
Emotional Illness:	Yes: ___	No:___	Name:_____	Dosage:_____	Time:___

Diagnosis: _____
Date of onset of illness or disability:_____
Cause:_____
Limbs affected:_____
If spinal cord involvement, what vertebral level?_____
If Down's Syndrome, please confirm x-rays show no atlanto-axial subluxation:_____

MOBILITY:

Can rider ambulate?	Yes: _____	No: _____	
With assistance:	independent: _____	minimal: _____	maximum: _____
With aids:	cane: _____	crutches: _____	walker: _____

Is Student a suitable candidate for equine-facilitated therapy? _____
Precautions: _____
Additional comments: _____
_____

Physician's signature: _____
Printed name: _____
Phone Number: _____
Date signed: _____
Date of last examination: _____

Please also complete the Medical History Chart - Below

MEDICAL HISTORY CHART

Please indicate if Student has any of the following secondary medical problems by checking "yes" or "no." If "yes," please include complete information pertaining to the problem.

Condition/Problem	Yes	No	If yes, please describe
Allergies			
Visual			
Hearing			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Metabolic/G.I./G.U.			
Bladder/Bowel Control			
Skin and Soft Tissue			
Surgeries (provide dates)			
Pain			
Seizures: Type? How Controlled? List medication and how administered Date of last seizure:			
Muscular/Contractures			
Skeletal (i.e., subluxing hips, scoliosis, kyphosis, lordosis)			
Fractures (indicate location, date and whether healed)			
Contagious condition(s)			
Other or Special Precautions			

Please include any additional information which might help us work with this Student:

_____

_____