BUTTERFLY DREAMS FARM

THERAPEUTIC RIDING PROGRAM, INC.
P.O. Box 622 | Watkinsville, GA 30677
www.butterflydreamsfarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Physician Statement Form

BDF Participant Name:		
BDF Therapist/Instructor:		**Date:**

Dear Health Care Provider:

Your above named patient is interested in participating in supervised equine activities. 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 may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic			Blood Pressure Control
	Atlantoaxial Instability – *incl. neurologic symptoms*		Dangerous to Self or Others
	Coxa Arthrosis		Exacerbations of Medical Conditions (i.e. RA, S)
	Cranial Deficits		Fire Settings
	Fractures		Hemophilia
	Heterotopic Ossification/Myositis Ossificans		Medical Instability
	Joint Subluxation/Dislocation		Migraines
	Osteoporosis		PVD
	Pathologic		Recent Surgeries
	Spinal Joint Fusion/Fixation		Respiratory Compromise
	Spinal Joint Instability/Abnormalities		Substance Abuse
Neurologic			Thought Control Disorders
	Hydrocephalus/Shunt		Weight Control Disorder
	Seizure	**Other**	
	Spina Bifida/Chiari II Malformation		Age – under 4 years for Therapeutic Riding
	Tethered Cord/Hydromyelia		Age – under 2 years for Hippotherapy
Medical/Psychological			Indwelling Catheters/Medical Equipment
	Abuse (Physical/Sexual/Emotional)		Medications – *i.e. Photosensitivity*
	Allergies		Poor Endurance
	Animal Abuse		Skin Breakdown
	Cardiac Condition		

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 Butterfly Dreams Farm at 706/310-1600.

Sincerely,

This is an initial letter to your participant's physician. Attach the Participant's Medical History & Physician's Statement.