easterseals Massachusetts

Equine-Assisted Services
ESMA Equestrian Center

Year: _____

PARTICIPANT MEDICAL HISTORY AND MEDICAL PROVIDER STATEMENT

Name: _____ Date of Birth: _____
Name of Parent/Guardian: _____
Diagnosis: _____ Date of Onset: _____
Height: _____ Weight: _____ Tetanus Shot: _____ Date: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: _____ Date of last seizure: _____
Shunt Present: _____ Date of last revision: _____

**** For those with Down Syndrome****
Cervical X-ray for Atlantoaxial Instability: Positive: ☐ Negative: ☐ X-ray date: _____
Neurologic Symptoms of Atlantoaxial Instability: _____

Please indicate any current or past needs in the following systems / areas, including past surgeries:

Special Needs	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary /Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional / psychological			
Pain			
Other			

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Mobility:
Independent Ambulation: _____ Wheelchair: _____ Braces: _____
Other Adaptive Equipment: _____
Please indicate any special precautions:

Check and describe all current therapeutic and safety issues:

☐	Inattention	
☐	Hyperactivity	
☐	Lack of Communication	
☐	Learning Disabilities	
☐	Developmentally Delayed	
☐	Cognitively challenged	
☐	Boundary issues	
☐	Social skills problems	
☐	Problems with peers	
☐	Separation anxiety	
☐	Anxiety	
☐	Phobias	
☐	Aggressive	
☐	Assaultive	
☐	Manipulative	
☐	Unpredictable or dangerous behavior	
☐	Sensory impairment	
☐	Sensitivity/preferences	
☐	Tics or stereotypic behavior	
☐	Psychosomatic symptoms	
☐	Medical issues	
☐	Self-injurious behavior	
☐	Suicidal ideations	
☐	Elopement	
☐	Issues of parental or family support	
☐	Sexual abuse	
☐	Physical abuse	
☐	Emotional abuse	

☐	Hallucinations	
☐	Delusions	
☐	Illusions	
☐	Dissociations	
☐	Substance abuse problems	
☐	Legal problems	
☐	School problems	
☐	Animal abuse	
☐	Fire setting	
☐	Seizure disorder	
☐	Medication side effects	

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities, including riding. I understand that Easterseals Massachusetts will weigh the medical information given against the existing precautions and contraindications.

Therefore, I refer this person to Easterseals Massachusetts for ongoing evaluation to determine eligibility for participation.

Signature: _____ Date: _____

Name: _____

Title: _____ License/UPIN Number: _____

Address: _____
Phone: _____