

Health History

Date: _____

Participant Information

Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ Age: _____ Gender: F / M

Medical History: Participants are required to have a health form completed and signed by a physician. Each health form must state that a physical has been completed within the past year and that all immunizations are up-to-date.

| Allergies To | Symptoms | Treatment (Please list epi-pen if prescribed) |
|--------------|----------|--|
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Are there any dietary restrictions:

Past medical treatments:

Please list any physical, mental, or psychological conditions requiring medication, treatment, or special restrictions/considerations. _____

Are there any activities to which you will be exempt for health reasons?

History of Seizures: Y or N

Last seizure: _____

Protocol in case of seizure: _____

Health History

Date: _____

Prescribed Epi-pen: Y or N (If yes, please list allergens):

If the participant is prescribed an epi-pen. I hereby request that:

- The epi-pen be kept on my child's own person at all times.
- The epi-pen be kept on my child's counselor's person at all times.
- The epi-pen be kept in the center's nurse's office at all times.
- I, as parent/guardian, will be responsible for having the epi-pen available as I will be present at all activities (riding center programs only).

AND I hereby request that:

- My child self-administer the epi-pen if needed, unless deemed incapable by staff.
- A trained staff member administer the epi-pen to my child if needed.

Parent/Guardian name: _____ Signature: _____ Date: _____

Asthma: Y or N (If yes, describe frequency, triggers, precautions, and treatments):

If the participant is prescribed an inhaler. I hereby request that:

- The inhaler be kept on my child's own person at all times.
- The inhaler be kept on my child's counselor's person at all times.
- The inhaler be kept in the center's nurse's office at all times.
- I, as parent/guardian, will be responsible for having the inhaler available as I will be present at all activities (riding center programs only).

AND I hereby request that:

- My child self-administer the inhaler if needed, unless deemed incapable by staff.
- A trained staff member administer the inhaler to my child if needed.

Parent/Guardian name: _____ Signature: _____ Date: _____

Medications To Be Given During Programs

All prescription medications must be provided in original containers, with patient's name, expiration date, and dosage directions. Over-the-counter medications must be in original containers.

Please list all medications to be administered during our programs

| Medication | Dosage | Times to be given | Days to be given | Special Instructions |
|------------|--------|-------------------|------------------|----------------------|
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Health History

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All Current Medication

Please provide information about all current medications, both prescription and over-the-counter, including vitamins and as-needed medication taken regularly. This information is collected in case of the need for emergency medical treatment.

| Medication | Dosage | Frequency | Purpose |
|------------|--------|-----------|---------|
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I request that the medication(s) be dispensed as described above.

Parent/Guardian Name Parent/Guardian Signature Date

The patient named above is in my care and I request that the medication(s) be dispensed as described above.

Physician's Name & License # Physician Signature Date

To the best of my knowledge, the information provided in this form is correct and up-to-date:

Parent/Guardian Name Parent/Guardian Signature Date

Medical History

Name: _____

Please indicate any medical problems or treatments in the areas outlined below.

| | Yes | No | Comments |
|--|-----|----|----------------------------|
| Auditory | | | |
| Ear Infections (if unusually frequent) | | | |
| Visual | | | Glasses/Contact lenses? |
| Speech | | | |
| Communication | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Pain | | | |
| Cardiac | | | |
| Chicken Pox (include date) | | | |
| Circulatory: PVD/Postural Hypertension | | | |
| Diabetes (specify type) | | | |
| Hemophilia | | | |
| Pulmonary, including Asthma | | | |
| Mononucleosis | | | |
| Neurological | | | |
| Hydrocephalus | | | If yes, shunt/# revisions: |
| Sensory Loss | | | |
| Muscular, including contractures | | | |
| Orthopedic | | | |
| Immunity | | | |
| Balance | | | |
| Skeletal | | | |
| Spinal Column Injury | | | |
| Subluxing Joints | | | |
| Dislocated Joints | | | |
| Laminectomy/Fusion | | | |
| Scoliosis | | | |
| Kyphosis/Lordosis | | | |
| Spondylolisthesis | | | |
| Spinal Abnormality | | | |
| Spinal Cord Compression | | | |
| Osteoporosis | | | |
| Heterothrophis/Ossification | | | |
| Joint Disease | | | |
| Cranial Defects | | | |
| Fractures | | | |
| Other | | | |

Riding Authorization:

Name: _____

If participants will be involved in any riding activities, this form must be signed by their physician.

To the Physician: Our horseback riding programs include therapeutic horseback riding, carriage driving and hippotherapy.

If the patient may be involved with horseback riding and/or hippotherapy, please choose:

- | | |
|---|---|
| <input type="checkbox"/> I recommend the above-named patient have the opportunity to ride a horse, and consent that s/he is not medically precluded from equine assisted activities and/or therapies. I understand that The Bridge Center will weigh the medical information given against existing precautions and contraindications. Furthermore, I have reviewed the conditions listed below that may present precautions or contraindications to horseback riding and noted relevant information. | <input type="checkbox"/> I do <u>not</u> recommend horseback riding activities for the above-named patient. |
|---|---|

Physician Name & License #: _____ Signature: _____

Date Signed: _____ Date of Health Exam: _____ Phone: _____

For Participants with Down Syndrome:

- | | |
|---|---|
| <input type="checkbox"/> Negative X-Ray for Atlantoaxial Instability (AAI): _____ | <input type="checkbox"/> Negative for Clinical Symptoms of Atlantoaxial Instability (AAI) |
|---|---|