



**Rider's Edge Ability Centered Horsemanship
(R.E.A.C.H.)
MEDICAL RELEASE
(Including Treatment Orders and Seizure Disclosure Statement)**

This form must be completed and signed by a health care professional and must be updated annually, or more frequently if needed:

The following conditions, if present, may represent **precautions or contraindications** to therapeutic horseback riding or hippotherapy. Therefore, please note if any of these conditions are present, and to what degree.

Please be as specific as possible so that we may best serve the participant's needs.

Participant: _____

Date of birth _____ **Height** _____ **Weight** _____

Primary diagnosis: _____

Please mark all conditions that are present and add specifics below:

Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation/ Dislocation
- Osteoporosis

Neurological

- Hydrocephalus/shunt
- Tethered Cord
- Atlantoaxial instabilities
- Chiari II Malformation
- Hydromyelia
- Paralysis/ spinal cord injury
- Seizure Disorder

Secondary Concerns

- Pathologic Fractures
- Hypertension
- Behavior Problems
- Hemophilia
- Coxas Arthrosis
- Serious Heart Condition
- Age under two years
- Heterotopic Ossification
- Stroke (Cerebrovascular Accident)
- Age two - four years
- Osteogenesis Imperfecta
- Exacerbation of chronic disorder
- Cranial Deficits
- Indwelling catheter (contraindication for females)
- Spinal Orthoses
- Internal Spinal Stabilization Devices

Medical

- Allergies
- Cancer
- Diabetes
- Peripheral Vascular Disease
- Poor endurance
- Recent surgery
- Varicose Veins

Other Condition(s) not listed above: _____

For participants with Down Syndrome Only

Please note:

Due to the nature of equine activities, including horseback riding, participants with Down Syndrome must have annual medical clearance from a licensed physician that includes a neurologic exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI). Please provide the following information:

Annual neurologic exam for AAI : Date of Exam _____ Exam results _____

Please indicate specifics for all existing health conditions, including degree of conditions such as scoliosis and osteoporosis, type of behavior problems, recent surgeries, type of seizures, location of catheters, etc:

Does the participant have any health concerns or surgeries in any of the following areas?

If yes, please explain below.

Auditory _____	Muscular _____
Visual _____	Orthopedic _____
Speech _____	Allergies _____
Cardiac _____	Learning Disabilities _____
Circulatory _____	Cognitive _____
Pulmonary _____	Mental Impairment _____
Neurological _____	Other _____

Please describe any concerns or special medical or physical precautions or adaptations needed:

HEALTH CARE PROVIDER'S STATEMENT

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Rider's Edge Ability Centered Horsemanship (R.E.A.C.H.) will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to R.E.A.C.H. for ongoing evaluation to determine eligibility for participation and implementation of an effective program. (For therapy – evaluation and treatment orders: once per week for 12 months)

Health Care Provider Name _____ Title _____

Office Address _____ City _____ State _____

License/UPIN Number: _____ Phone: _____

REQUIRED:

Health Care Provider Signature _____ **Date:** _____

Please return completed form in person or via email or mail to:
R.E.A.C.H at Wood's Edge Equestrian Center
15051 W. 191st Olathe, KS 66062
reachatwoodsedge@gmail.com
Phone: (913) 660-5107

R.E.A.C.H. - Seizure Disclosure Statement

This form must be signed by a health care professional and must be updated annually if participant has a history of seizures

Participant's Name _____ Date _____

_____ This participant currently has no known history of seizures

Seizure Disclosure – physician’s signature required ONLY if participant has a history of seizures

All participants with a history of any seizures must provide the following information:

Type of seizures:

Typical aura (pre-seizure sensations or behaviors):

Typical motor activity during seizures:

Frequency of seizures (how many seizures per week, month, etc.): _____

Average duration of seizures: _____

Any known triggers for seizure activity: _____

Any routine medications taken and any side effects (drowsiness or photosensitivity):

Any medications or special procedures to prevent or control seizures on an as needed basis, including nasal spray, suppository, VNS magnets, etc.:

Date, type and duration of most recent seizure activity:

Date _____ Type _____ Duration: _____

I have reviewed the Seizure Disclosure information and to the best of my knowledge the information disclosed above is accurate and complete. I have no concerns about the above named person participating in equine assisted activities and therapies and understand that Heartland Therapeutic Riding has the right to decline services if it is determined that there is a contraindication present at any time in the future.

***PHYSICIAN'S SIGNATURE REQUIRED If participant has any known history of seizures:**

Physician's Signature: _____ Date: _____

Seizure Policies – PLEASE READ

1. Participants with any history of seizures must submit a Seizure Disclosure Statement signed by a physician prior to participating in any R.E.A.C.H. programs.
2. If participant has a history of any of the following types of seizures, an adult responsible for that participant (parent, guardian, caregiver) must be **in sight** of said participant at all times while the participant is mounted:
 - **Generalized tonic clonic seizures (grand mal)** – includes loss of consciousness, stiffening of body (tonic) followed by jerking of the muscles (clonic).
 - **Myoclonic seizures** – consciousness is not affected, brief but intense muscle jerks usually involving the upper body. May sometimes lead to clonic tonic seizures.
 - **Tonic seizures (drop attacks)** – sudden, brief stiffening of the whole body, usually result in falling, no loss of consciousness.
 - **Clonic seizures (drop attacks)** – sudden, brief loss of muscle tone throughout body. Body goes limp and person will collapse, no loss of consciousness.
3. R.E.A.C.H. Staff must be notified of any new seizure activity, including any changes in frequency or type of seizures. Failure to notify R.E.A.C.H. Staff may result in dismissal from the program.
4. Participants may not ride within 24 hours of a generalized tonic clonic (grand mal) seizure. Please notify R.E.A.C.H. that participant will be absent if a seizure occurs within 24 hours of scheduled ride time.
5. Any medications or procedures (including magnets for VNS) that must be administered to participant to prevent or control seizures must be administered by an adult responsible for that participant (parent, guardian, caregiver). Medications and/or procedures will not be administered by R.E.A.C.H. Staff.
6. According to PATH Intl. Standards, the following conditions are contraindications to riding for participants with seizures. If a listed condition is present, participation will be prohibited from riding until the condition is no longer present:
 - Recent seizure activity accompanied by strong, uncontrollable motor activity or atonic or drop attack seizure due to their sudden and complete loss of postural muscle tone.
 - A change of frequency or type of seizure until the condition is evaluated
 - Inability to manage a participant during an emergency dismount should a seizure occur.
7. R.E.A.C.H. instructors and therapists working directly with a participant with a known history of seizures will have access to the R.E.A.C.H. *Seizure Disclosure Statement* for that participant. Volunteers working with a participant with a history of seizures will be made aware of pertinent information by the instructor or therapist for the participant's safety.
8. Participants who have a seizure (of any of the type listed above) while mounted or fail to disclose recent seizure activity or changes in frequency may be dismissed from the program at R.E.A.C.H. discretion.

If there is a history of seizures, a Seizure Disclosure Statement has been signed by a physician and the information disclosed above is accurate and complete to the best of my knowledge. I have read the Seizure Policies above and understand and agree with all the policies listed. I further understand that it is my responsibility to disclose any new seizure activity or any change in frequency of seizures for the duration of my (my child's) participation in any R.E.A.C.H. program and that failure to do so may result in dismissal from the program. Signature required:

Date: _____

(Signature of Participant (Parent/Guardian, if minor))