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

Medical

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

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

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 AAl : Date of Exam _____________________ Exam results________________________________

Updated 8/10/2019

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:

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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 occupational therapy evaluation and treatment: 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
Phone: (913) 660-5107 Email: reachatwoodsedge@gmail.com

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: _________________

Updated 8/10/2019

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)