



Saving Grace Farm
725 Jackson Rd.
Salisbury, NC 28146
(704) 209-6577 phone (704) 603-3022 fax
www.savinggracefarm.com



Date: _____

Dear Health Care Provider:

Your patient, _____
(participant's name)

is interested in participating in supervised equine-assisted services at Saving Grace Farm. These activities may be mounted or unmounted based on staff evaluation of the participant's goals and safety. 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, please indicate whether these conditions are present and any relevant severity or considerations.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered
Cord/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraine
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted services, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Janna Griggs, Executive Director

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Participant's Medical History & Physician's Statement

(to be completed by a licensed physician)

Please fill this out to the fullest extent possible. Please send securely or fax this form to 704-603-3022

Participant: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____ Shunt Present: Y N

Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: Any concerns for Atlantoaxial instability or cervical spine precautions?

Yes No If yes, specify restrictions/precautions: _____

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Based on the above information, there are no medical contraindications to this individual's participation in equine-assisted activities, with the considerations noted above. The client is cleared to participate as indicated below:

Initial one: _____ **Ground ONLY equine activities** _____ **Either ground or mounted (riding) equine activities**

I understand that Saving Grace Farm staff will evaluate this individual's participation based on the medical information provided and established precautions and contraindications.

Name/Title: _____ **MD DO NP PA Other** _____

Signature: _____ **Date:** _____

Address: _____

Phone: (____) _____ **License/UPIN Number:** _____