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Our Board Members are Volunteers -
Giving of their Time & Talents to



Therapeutic Riding Academy

P.O. Box 3975 Rapid City, SD 57709
605 673-2935 Cell 605 484-4883
Fax 605 673-4747 SunCatcherTRA@aol.com
www.suncatchertra.org

Date _____

Dear Physician:

Your patient, _____, is interested in
(Participant's Name)
participating in supervised equestrian activities.

In order to safely provide this service, 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	Medical / Psychological
Atlantoaxial Instability – include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Physical / Sexual / Emotional Abuse
Heterotopic Ossification / Myositis Ossificans	Blood Pressure Control
Joint subluxation / dislocation	Dangerous to self or others
Osteoporosis	Exacerbation of medical conditions
Pathologic Fractures	Fire Settings
Spinal Fusion / Fixation	Heart Conditions
Spinal Instability / Abnormalities	Hemophilia
	Medical Instability
Neurologic	Migraines
Hydrocephalus / Shunt	PVD
Seizure	Respiratory Compromise
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia	Recent Surgeries
	Substance Abuse
Other	Thought Control Disorders
Age – under 4 years	Weight Control Disorder
Indwelling Catheters	
Medications – i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

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

Sincerely,

Linda S

Linda Smedshammer, Exec/Prog Director



A Member of North American Riding for the Handicapped Assn