DREAMS ON HORSEBACK
Equine Education for Disadvantaged Youth

Special Olympics

Medical History

Participant name:_____ Date of Birth:_____
Address:_____ City:_____ Zip:_____
Male / Female Height:_____ Weight:_____
Participant is a (circle one): minor adult with legal guardian independent adult
Name of Parent(s)/ Guardian(s):_____
Current diagnosis:_____
_____

Mobility: Ambulatory- yes/no Crutches- yes/no Braces- yes/no Wheelchair- yes/no Walker- yes/no
Is the participant able to sit independently for one hour without support? yes/no
Is the participant able to accept and bear weight through their legs? yes/no
Medications:_____
Allergies to Medications:_____
Allergies to any food, insect bite, plants, animals, other:_____
History of Asthma?_____
Does the participant carry an EpiPen? yes/no Does the participant carry an inhaler? yes/no

Medical: Please indicate whether or not the participant has any of the following conditions:

Has the participant every been treated for any of the following?	**Yes or No**	**Details and Age of diagnosis (Use additional paper if necessary)**
Conditions of the spine, including, but not limited to spinal cord injury, curvature, fusion, instability, abnormalities or Spina Bifida		
Brain injury, including stroke		
Pathologic fractures		
Fatigue or limited endurance		
Immune Deficiency		
Bleeding or Clotting Disorders		
Diabetes		
Joint contractures, Cerebral Palsy, or hip dysplasia		
Skin breakdown or pressure sores		
Behavioral issues		
Emotional & Psychological issues		
Other		

List precautions: for example: shunts, feeding tubes, catheters, etc._____

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Health History

1. In the past 12 months, has the participant been hospitalized for any serious injury, condition or surgery? Yes / No
If yes, please explain:_____
_____

2. In the past 12 months, has the participant experienced loss of consciousness, traumatic or otherwise, including seizures of any type? Yes / No
If yes, please explain:_____
_____

3. In the past 12 months, has the participant experienced a psychotic crisis? Yes / No
If yes, please explain:_____
_____

4. In the past 12 months, has it been necessary to restrict the participant's activities due to medical reasons? Yes / No
If yes, please explain:_____
_____

5. Is participant unable to maintain upright sitting posture or head control without assistance?
Yes / No If no, please explain:_____
_____

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

A PHYSICIAN's RELEASE is required if:
_____ Participant has Down Syndrome
_____ If any of the Health Questions, (#'s 1, 2, 3, 4 or 5) are answered YES
_____ If the participant has been treated for any of the CONDITIONS listed in the Health questions.

A SEIZURE EVALUATION FORM is required if:
_____Participant has experienced seizure activity within the past 12 months

Signature of Person completing the Health History:_____
Relationship to Participant:_____ Date: _____