Vermont Adaptive Ski and Sports (VASS) at MoonRise Farm

8006 Butternut Lane, Taftsville, VT 05073
802-345-5637

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant_____Parent/Guardian_____
Date of Birth_____ Height_____ Weight_____
Diagnosis_____ Date of Onset_____
Medications_____
Seizures: ____Yes ____No Type_____
Controlled: ____Yes ____No Date of last seizure_____
Tetanus Shot: ____Yes ____ No Date of last shot/booster _____

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VASS at MoonRise Farm is a therapeutic riding program designed to benefit participants physically, socially and emotionally. Safety equipment, specially trained horses and volunteers are part of the program. In order to assure optimal protection and the greatest personal benefit from the program, we are asking you to furnish the following medical information.

***Note:** Because of the nature of the activity of horseback riding, individuals with the diagnosis of **Down Syndrome** may not be able to ride **without proof of a negative diagnostic X-ray for atlanto-axial dislocation condition.**

X-ray Date_____Positive Negative (please circle one).

Please indicate if impairments exist in any of the following areas by checking yes or no. If yes, please comment, using attachments if necessary.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac/Circulatory			
Pulmonary			
Neurological			
Muscular/Orthopedic			
Learning Disability			
Allergies			
Cognitive Impairment			
Other			

Mobility_____ Ambulation (with or without assist): ___Yes ___No
Assistive Device:_____ Wheelchair User ____Yes ____No
Please indicate any other special precautions_____
_____
Other Comments_____
_____
_____

Physician Release:

In my opinion, this individual can participate in supervised riding activities. As relates to these activities, I concur with the referral of this individual to a physical or occupational therapist or other health care professional, if indicated, for evaluation of their abilities/limitations, in order to implement an appropriate and effective therapeutic riding program.

Physician Name (please print)_____
Phone_____Address_____
Physician Signature_____ Date_____