Thorncroft Equestrian Center
190 Line Road, Malvern, PA 19355
Office: 610.644.1963 *Fax: 610.644.9342* www.thorncroft.org

Welcome Packet – New Riders

Name:_____ Today's Date: _____

In order to meet the needs and develop the goals of our riders and their parents, we need the following information:

Rider Release Form

Medical History

Classroom Individual Education Plan (I.E.P.)

Physical Therapy Evaluation, Assessment and Program Plan

Occupational Therapy Evaluation, Assessment and Program Plan

Speech Therapy

Mental Health Diagnosis and Treatment Plan

Cognitive-Behavioral Management Plan

For riders with Down Syndrome, a **yearly** neurological exam, signed and dated by a physician, stating no changes in AAI (atlantoaxial instability).

Other:_____

Please check off above any of the items that are attached.

MEDICAL HISTORY

(To be completed every three years)

TO BE COMPLETED AND SIGNED BY PHYSICIAN

(Please write legibly)

NAME _____DATE:_____PHONE: _____

E-MAIL ADDRESS: _____

ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____SEX:_____HEIGHT:_____WEIGHT:_____ (200 lb. limit)

PARENT/GUARDIAN NAME: _____

HEALTH INSURANCE COMPANY: _____POLICY NUMBER: _____

Physical Disabilities: Yes____ No ____

Intellectual Disabilities: Yes____ No ____

Emotionally Disturbed: Yes____No____Learning Disabled: Yes____No ____

PRIMARY DIAGNOSIS: _____

Cause: _____Onnset:_____

Limbs Affected: _____

If Spinal Cord Injury, what vertebral level? _____

If Down Syndrome, is Atlantoaxial Instability present (AAI):_____

If Down Syndrome Date of most recent Cervical Spine X-ray:_____. Age at time of most recent X-ray:_____

Estimate of mental ability: _____

MOBILITY STATUS:

Can the student ambulate? Yes____ No____

Assistance: Independent_____ Minimal _____Moderate ____Maximal____

Physical Aids: Canes _____Crutches _____Walker _____Braces_____Wheelchair____

Please provide additional information relevant to how we may best accommodate this student.
(Medications, fears/concerns, support system, other interests, etc. and precautions)

_____

_____

Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

Condition:	Yes	No	Description (PLEASE PRINT)
ALLERGIES			
VISION			
HEARING			
COMMUNICATION/SPEECH			
CARDIAC **Pulse: Blood Pressure:**			
CIRCULARTORY **Hemophilia:**			
PULMONARY			
METABOLIC/G.I.G.U . **Diabetes, Bladder/Bowel**			
SKIN & SOFT TISSUE **Pressure sores**			
PAST/RECENT SURGERY			**Date(s)**
CRONIC PAIN			
MEDICATION(S)			
NEUROLOGICAL			
SEIZURE			**Controlled : Yes/No** **Type :** **Date of Last: If Yes, How often** **Indications of Seizures :**
BEHAVIORAL			
MUSCULAR/Contractures			
SKELETAL (A) - **Subluxing Hips, Fractures**			
SKELETAL (B) - **Scoliosis , Kyphosis , Lordosis,**			**Degrees:**
CONTAGIOUS CONDITION			

By signing below I affirm horseback riding is NOT a contraindication for this individual. I understand Thorncroft will weigh the medical information given against the existing precautions and contraindications. I refer this person to Thorncroft for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ **Date:** _____

Physician's Name (Please Print):_____**Phone:**_____

Office Name/Address: _____

THORNCROFT - THERAPEUTIC HORSEBACK RIDING REFERRAL
PLEASE WRITE LEGIBLY AND IN DETAIL

Rider Questionnaire

Why will therapeutic riding be a good activity for the rider?

Are there specific goals the rider would like to achieve through therapeutic horseback riding?

What other types of therapy does the rider currently receive?

Please share with us the rider's learning style (strengths and weaknesses).

By signature, I confirm that all attached medical information is current and accurate to the best of my knowledge.

Rider/Parent/Guardian (*circle one*) Signature: _____Date: _____

Print Signature_____ Date: _____