



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

Rider Packet

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: _____ Onset: _____

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:			
CIRCULATORY 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.

(when this rider is attached to a form in lieu of TEC medical form, parent/guardian/caretaker assumes responsibility & risk for any incomplete medical information not brought to the attention of Thorncroft Equestrian Center & relinquishes TEC from any liability.)

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

Print Signature _____ Date: _____