

Nipper Knolls Inc.

196 Aunev Way Granville NY 12832
518-642-2252

Physician's Prescription

Participant's Medical History

Participant: _____ D.O.B: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of last seizure: _____

Shunt Present: Y N Date of last revision: _____ Special Precautions/Needs _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down syndrome: AtlantoDens Interval X-rays: Date: _____ Results: + -

Neurologic Symptoms of Atlanto Axial Instability: _____

Please indicate current or past special needs in the following systems/area, including surgeries:

Concern/Need:	Yes	No	Comments:	Concern/Need:	Yes	No	Comments:
Auditory				Neurologic			
Visual				Muscular			
Tactile Sensation				Balance			
Speech				Orthopedic			
Cardiac				Allergies			
Circulatory				Learning Disability			
Integumentary/Skin				Cognitive			
Immunity				Emotional/Psych.			
Pulmonary				Pain			
Other:							

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies.

I understand that the therapist/ instructor will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Nipper Knolls Inc. for ongoing evaluation to determine eligibility for participation.

Physician Prescription:

Therapeutic/Adaptive Riding and Horsemanship lessons for 12 months

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ License/UPIN Number: _____