PHYSICIAN'S STATEMENT

1000 Ability Way, Park City UT 84060
reservations@discovernac.org
p: (435) 649.3991 f: (435) 658.3992
www.discovernac.org

ATTENTION HEALTH CARE PROVIDER

Required for Adaptive Horseback Riding & Camps

Dear Health Care Provider: Your patient, ____ , is interested in participating in programs with the National Ability Center. In order to safely provide this service, the National Ability Center requests that you complete the following information. Note that the following conditions may suggest precautions and contraindications to participation in equestrian programs. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation, feel free to contact the National Ability Center.

Y	N	Orthopedic	Details	Y	N	Medical/ Psychological	Details
		Required for those with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability	AtlantoDens Interval X-rays: Date: ________________ Result:______________________ ____________________			Allergies	
		Coxarthrosis				Animal Abuse	
		Cranial Defects				Cardiac Condition	
		Heterotopic Ossification/Myositis Ossificans				Physical/Sexual/Emotional Abuse	
		Joint Subluxation/dislocation				Blood Pressure Control	
		Osteoporosis				Dangerous to self or others	
		Pathologic Fractures				Exacerbations of Medical Conditions (RA, MS, Fibromyalgia, etc.)	
		Spinal Joint Fusion				Fire Setting	
		Spinal Joint Instability/Abnormalities				Hemophilia	
Y	**N**	**Neurologic:**	**Details**			Medical Instability	
		Hydrocephalus/Shunt				Migraines	
		Seizure				Peripheral Vascular Disease	
		Spina Bifida/Chiari II Malformation/ Tethered Cord/Hydromyelia				Respiratory Compromise	
Y	**N**	**Other:**	**Details**			Recent Surgeries	
		Indwelling Catheters/Medical Equipment				Substance abuse	
		Medications (Photosensitivity?)				Thought Control Disorders	
		Poor Endurance				Weight Control Disorder	
		Skin Breakdown				**Other:**	

Participant's Full Name: ____ Date of Birth: _______________________

Diagnosis – Primary: _______________________________________ Secondary: ____

Age: __________________ Height: __________________ Weight: __________________

Given the diagnosis and medical information, this person is not medically precluded from participation in the selected programs and/ or therapies. I understand that the National Ability Center will weigh the medical information given against the existing industry standard precautions and contraindications. Therefore, I refer this person to the National Ability Center for ongoing evaluation to determine eligibility for their participation.

Physician Name & Title: ____ MD DO NP PA Other: _____________

Address: ____

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

Signature: ____ Date: ____

Revised: 1/26/2024