

Walk On
P.O. Box 376
Barrington, IL 60011
Phone: 847-381-4231 Fax: 847-381-4288

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 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/Splints/Orthotics, Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-Rays, Date: _____ Result: + --
 Neurologic Symptoms or AtlantoAxial Instability: _____

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

System/ Area	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Walk On will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Walk On for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other: _____
 Signature: _____ Date: _____
 Address: _____
 Phone: _____ License/UPIN Number: _____