



**Disability Resource Association**  
 420 South Truman Blvd.  
 Crystal City, MO. 63019  
 Phone (636) 931-7697 Fax (636) 931-4863  
**Participant's Medical History & Physician's Statement**  
**DRA Healing With Horsepower Equine-Assisted Therapy**

Participant \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Address \_\_\_\_\_  
 Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_  
 Past/Prospective Surgeries \_\_\_\_\_  
 Medications \_\_\_\_\_  
 Seizure Type \_\_\_\_\_ Controlled Y N Date of last seizure \_\_\_\_\_  
 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 \_\_\_\_\_

Result: + --

Neurologic Systems of AtlantoAxial Instability: \_\_\_\_\_

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

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

	Y	N	Comments
<b>Pain</b>			
<b>Other</b>			

**Participant's Medical History & Physician's Statement  
For DRA Healing With Horsepower Equine-Assisted Therapy**

**Given the above diagnosis and medical information, this person is medically capable to participate in equine assisted activities. I understand that the North American Riding for the Handicap Association, Inc. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.**

**Name/Title** \_\_\_\_\_ **MD DO NP PA Other** \_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Phone**(\_\_\_\_) \_\_\_\_\_ **License/UPIN Number** \_\_\_\_\_