Burlington, CO 80807
(719)346-7623 – (719) 346-0337
pharomummy@centrurytel.net

Physician's Statement

Rider ____ DOB___________________

Sex ____ Height ______ Weight ________ Pulse _______ Blood Pressure __________________________

Diagnosis/Presenting Problem (REQUIRED):

____

____

Medications: ____

Allergies: ____

Date of last Tetanus shot ____________ OR ______ has not received; reason _______________________

In case of Down's Syndrome:

On examination of cervical spine X-rays including full flexion and full extension views, I find the above named person as:

Check one _____ No evidence of Atlantoaxial instability
_____ Positive or equivocal evidence of Atlantoaxial instability

Current findings or concerns, Precautions or Contraindications (for a list of possible Precautions of Contraindications, please refer to the PPTRC Physician's Letter):

____

____

____

Mobility status:
Ambulatory: ☐yes ☐no Check if patient uses: ☐wheelchair ☐walker ☐crutches ☐cane
Prosthetics/orthotics: ☐yes ☐no Describe: ____

____

Other: Please give any other information that you feel is important _________________________________

____

____

In my opinion, this patient can receive horseback riding instruction under appropriate supervision.

____

Physician's signature *Date*

____

Name (Please print or type) *Phone #*

____

Address