C 2 It, LLC @ CIRCLE C Equine Assisted Therapy

MEDICAL HISTORY/RELEASE

Participant Name_____Date of Birth_____
Health Issue(s)_____Weight_____
Diagnosis, if applicable_____Date of Onset_____
**FOR PERSONS WITH DOWN SYNDROME:
Cervical x-ray for Atlanto-axial instability: Date_____ positive_____ negative_____
Tetanus Immunization: Date_____
Seizures: ___no ___yes: Type/describe_____
Medications_____Allergies_____

Past surgery_____

Mobility: Independent ambulation Crutches Braces Wheelchair Other_____

AREA DESCRIPTION (if there is an issue)

Hearing_____

Vision_____

Speech_____

Cardiac/Circulatory_____

Respiratory_____

Neurological_____

Balance/Coordination_____

Orthopedic_____

Cognitive/Learning _____

Behavioral/Emotional/Social_____

Other_____

Please indicate any special precautions_____

Parent/GuardianSignature_____Date_____

Those with disabilities or current health issues are requested to have a health care provider complete the following:

FOR HEALTH CARE PROVIDER:

Given the above information, this person is not medically precluded from participating in supervised

equestrian activities with C2 It, LLC.

Signature_____ MD PA NP Other Date_____

(Please attach prescription for Physical, Occupational, or Speech Therapy if applying for Hippotherapy services)

Name(Print)_____Phone_____

Address_____City_____State_____Zip_____

Comments

Thank you for your assistance with this application. RETURN TO PO BOX 244 GRAYSON
Or leave on site.