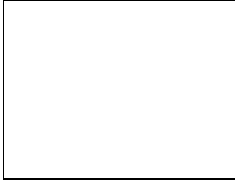
New Zealand Riding for the Disabled Association Incorporated



Group Letter Head / Logo

This form is to be completed by the Rider's doctor before starting the riding programme. Please also attach a copy of separate sheet 'Information for Physician'

Medical Consent

Name ______________________ Date of Birth ______________________

Address ______________________ Telephone ______________________

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I give permission for Dr ______________________ to supply relevant medical information to the ______________________Group RDA for the purpose of establishing a riding programme.

Signed ______________________ Dated ______________________
(Rider/Parent/Legal Guardian)

Diagnosis ______________________

Surgical Procedures/or Devices/or Orthoses ______________________

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Medication ______________________

Allergies ______________________

Epilepsy ______________________

Infectious Diseases ______________________

Other Relevant Information/Precautions ______________________

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In my opinion this person can participate in a riding programme and associated activities with appropriate supervision.

Physician's signature ______________________
Physician's name ______________________
Address ______________________ Tel/Fax ______________________
______________________ Date

Please return this completed form to: ______________________ Group RDA
Address: ______________________
Received by: ______________________ Date: ______________________

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Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing the **Medical Consent Form**, please note whether these conditions are present, and to what degree.

Orthopaedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilisation Devices

Medical / Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Haemophilia
Hypertension
Serious heart Condition
Stroke (Cerebrovascular Accident)

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns

Behaviour Problems
Age under two years
Age two – four years
Acute Exacerbation of Chronic Disorder
Indwelling Catheter

For persons with Down Syndrome a Cervical X-Ray for Atlantoaxial Instability may be required.

For information on precautions and contraindications please contact ________________________

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