P.O. Box 463
Maple Plain, MN 55359
(952) 934-0057
Fax: (952) 974-9688
www.wecanride.org

2021 Down Syndrome Atlantoaxial instability

MUST BE COMPLETED BY A CLINICIAN

Please return to the We Can Ride office.

Atlantoaxial instability (AAI) is a potentially life-threatening or paralyzing condition common to people with Down Syndrome. *We Can Ride* requires Clients with Down Syndrome to provide **annual** certification from a Physician, that the Client's annual physical examination reveals no symptoms of AAI such as change of head control, change in gait, change of hand control, or change in bowel or bladder functions.

Following the initial x-ray, indication for repeated x-rays should be made at the discretion of the Client's Clinician.

Client Name:_____

Date of Exam:_____

_____ No clinical symptoms of Atlantoaxial instability were seen during the exam.

_____ Yes, clinical symptoms of Atlantoaxial instability were observed. Horseback riding is contraindicated at this time.

_____ Flexion/extension cervical spine x-ray for AAI

Result: _____ Date of x-ray: _____

CLINICIAN NAME (PRINT): _____ **DATE** _____

OR STAMP ADDRESS HERE:

CLINICIAN SIGNATURE: _____

(FORM CAN BE SIGNED BY PHYSICIAN, CERTIFIED NURSE PRACTITIONER OR PHYSICIAN ASSISTANT)

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

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We Can Ride
2021 Scoliosis Form

Orthopedic Physician Signature Required

Return to office

The following client has requested to participate in horseback riding activities with our program. These activities may include walking and/or trotting while on horseback, which can produce compression forces in the spine. Due to their diagnosis of scoliosis, we want to be sure that horseback riding activities are appropriate for this client. Our guidelines suggest that anyone with a spinal curvature > 30 degrees requires additional caution and physician approval. *Please* indicate the 1) degree of curvature this client has, 2) if there are any precautions you would like us to follow and 3) if it is appropriate to participate in our program.

Client Name:_____**Date of Exam**:_____

Area of Curvature:

Thoracic ☐ Degree of Curve:_____
Overall affect:_____
_____
_____

Lumbar ☐ Degree of Curve:_____
Overall affect:_____
_____
_____

If any precautions please list here:_____
_____
_____
_____

In my opinion, this patient can receive horseback riding under appropriate supervision. However, I understand that *We Can Ride, Inc*. will determine whether they can safely provide services.
Physician
Name(Print):_____Signature:_____
Date:_____ Stamp Address Here:
Address:_____
City/State/Zip_____
Phone:_____
E-mail:_____

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We Can Ride
2021 Seizure Form
Submit to office

A Seizure form is *required* for all clients with any seizure activity in the *last 5 years*.
Frequency of seizures varies widely and cannot always be predicted. We Can Ride wants to prepare our horses, staff, and volunteers for correct and safe procedures to ensure client safety in case of a seizure. ***Notify your instructor or WCR staff person as soon as possible if any changes occur!***

If a seizure has occurred in the past 3 years please have the client's physician fill out & sign!

Client Name: _____

Type of seizure: _____

Typical aura/pre-seizure sensations or behaviors during seizure: _____

_____

_____

Typical motor activity during seizure: _____

_____

Average duration of seizure: _____

Current frequency of seizures: _____

Date of last seizure: _____

Description of behavior during the recovery state and its duration: _____

_____

_____

What to do if seizure occurs at center: _____

_____

In my opinion, this client can receive horseback riding therapy under appropriate supervision. However, I understand that *We Can Ride, Inc.* will determine whether they can safely provide services.

Physician Name (Print):_____ Signature:_____
Date:_____ Parent Signature:_____
Address:_____ Physician Stamp Here:
City/State/Zip_____
Phone:_____

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We Can Ride

2021 Spina Bifida Form

Submit to office

Client Name: _____

PATH Centers are concerned about the symptoms of Spina Bifida. The equine's movement mobilizes and compresses the spine during seated mounted activities, involving the head and neck as well as lower spine. The seated nature of riding also requires that a rider/family member/staff must be able to monitor skin integrity during riding sessions. Monitoring any symptoms of Spina Bifida and associated diagnoses is essential to the safety and wellbeing of the rider. We ask for your input regarding the following:

Level of the defect (i.e. equipment used for daily living/ambulation, cognitive function, sitting balance, muscle strength and sensation): _____

_____

Associated medical problems: _____

_____

Shunt: *Circle: Y / N* Describe location:_____

Scoliosis: *Circle: Y / N* Describe location/severity:_____

Hydromyelia: *Circle: Y / N* _____

Chiari II Malformation: *Circle: Y / N*_____

Tethered Cord: *Circle: Y / N* If Yes, please indicate date of surgical correction (if applicable):

_____

Are any of the above symptomatic? (*If so, please indicate which associated diagnosis)*:

_____

Completed by
Parent/Guardian (Name): _____**Date:** _____