

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

2022 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 2022 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
2022 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: _____