LoveWay, Inc. Equine Assisted Services
54151 County Road 33 Middlebury IN 46540
574-825-5666 **Fax: 574-825-8117**
Email: programs@lovewayinc.org

PHYSICAL FORM FOR THE DOCTOR

Participant's Name_____ Participant's School_____

Address _____City, State, Zip_____

Information below must be filled out by physician.

Date of Birth_____ Age_____ Height: _____ Weight**:** _____ Male ( ) Female ( )

Diagnosis/disability: _____

Current medical status/condition:
_____

***Date of last seizure and type*: _____**

Precautions and physical limitations: _____

_____

For those with Down syndrome: Annual exam for Neurologic Symptoms of Atlantoaxial Instability was completed on Date_____ Symptoms of AAI are: ☐ **present** ☐ **absent**

Horseback riding is an approved activity: ☐ **Yes** ☐ **No**

Current medications and the reason they are prescribed. Include over the counter medications. Please use an additional page as needed.

_____

Additional Comments: _____

_____

Doctor's Office Information & Signature

I understand that the above medical information will be used by LoveWay, Inc. as part of a comprehensive evaluation to determine the extent to which the person will participate in therapeutic horseback riding at LoveWay, Inc.

Printed Name___ _____ **MD DO NP PA Other**_____

Doctor's Signature_____ **Date**_____

License/UPIN Number_____ **Phone**_____

Office Address_____ **City**_____