RED Arena, Inc.
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2435 W.Fitzhugh Rd. Dripping Springs, TX 78620
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Office: 512.221.5036 REDarena.org Fax: 512.861.2355

Physician's Statement

to allow participation in equine activities

Participant's Full Name:_____

DOB:_____

Height:_____ Weight: _____

Diagnosis: _____

_____

Medications: _____

_____

_____

Type of Seizures (if any): _____

Ongoing referral for PT/OT once weekly x 12 months.

Surgery : _____ Date: _____
Surgery: _____ Date:_____
Surgery: _____ Date:_____

☐ Atlanto-Occipital stability has been confirmed by x-ray for patients with Down Syndrome.

I understand this patient would like to participate in equine assisted therapies and/or activities which involves being near and riding on horses. There are no restrictions or contraindications with regard to this patent's physical condition to limit participation in horseback riding with a licensed therapist or PATH certified instructor.
Concerns/precautions (if any): _____
_____
_____
_____

_____ _____
Physician's Signature Date

_____
Physician's Printed Name