S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Participant's Consent for Release of Information

1. Participant Information
Full Name: ____ Date of Birth: _______________________

2. Authorization to Share Records
I hereby authorize LifeStriders to release to AND receive information from:
Organization/Name: ____
Contact Info (Email/Phone): ____

3. Information to be Released Check all that apply:
[ ] Physical Therapy evaluation, assessment, and program plan
[ ] Occupational Therapy evaluation, assessment, and plan
[ ] SLP (Speech) evaluation, assessment, and plan
[ ] Counseling / Mental Health Records
[ ] Social Skills or Cognitive Behavioral Management Plan
[ ] Billing and Payment Records
[ ] Other: ____

4. Purpose & Expiration
Purpose of Disclosure: ____
Expiration Date: This authorization will expire one year from the date of signature unless otherwise specified here: ___________________________

5. Acknowledgments & Rights
• I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.
• I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
• I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

____ _____________________
Signature of Client or Legal Guardian Date

Please send materials to: - -

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Participant's Medical History & Physician's Statement
(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant: ____________ DOB: ______ Height: ______ Weight: ______

Address: ____________

Diagnosis: ____________ Date of Onset: ______

Past/Prospective Surgeries: ____________

Medications: ____________

Seizure Type: ______ Controlled: ☐ Y ☐ N Date of Last Seizure: ______

Shunt Present: ☐ Y ☐ N Date of last revision: ______

Special Precautions/Needs: ____________

Mobility: Independent Ambulation ☐ Y ☐ N Assisted Ambulation ☐ Y ☐ N Wheelchair ☐ Y ☐ N

Braces/Assistive Devices: ____________

For those with Down Syndrome: AtlantoDens Interval X-rays, date: ______ Result + -

Neurologic Symptoms of AtlantoAxial Instability: ____________

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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Physician's Order for Occupational Therapy/Physical Therapy/Individual Counseling/ Group Therapy

(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant: ______________________________________**has been deemed eligible for:**

______________Occupational therapy services based on evaluation

______________Physical therapy services based on evaluation

______________Individual Counseling and/or Group Therapy services based on evaluation

Participants Name:______________________________________ Birthdate:___________________

Parent/Guardian______________________________________

Address:______________________________________ Phone:___________________

Physician: Please complete the items below. The form may be returned to your client, or to LifeStriders via fax or email. If clinics own prescription form is required, please be sure to include it in the returned packet. Thank you!

____________Please provide Occupational Therapy services as needed
____________Please provide Physical Therapy services as needed
____________Please provide Individual Counseling/Group Therapy services as needed

Medical Diagnosis/Description of Disability:____
____

Precautions/Contraindications:____
____

Additional Comments:____
____

This referral form will be valid for **1 year**, unless services are terminated, there is a change in the above mentioned participant's medical status, or an updated order is necessary.

Physician's Name:____

Phone:____

Address:____

Physician's Signature:______________________________________ Date:____________________________

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Medical Professional's Statement & Evaluation

(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant Name: DOB: ____/____/________

Section 1: Clinical Assessment of Movement Risks

The participant listed above wishes to engage in equine-assisted activities. These activities involve a horse's rhythmic, three-dimensional movement which mimics the human gait but can place significant stress on the spine, internal organs, and cardiovascular system.

Please check any conditions that apply to this patient:

Category	**Potential Contraindications / Precautions**
Orthopedic	[ ] Atlantoaxial Instability (Required for Down Syndrome) [ ] Spinal Fusion or Internal Hardware (within last 12 months) [ ] Scoliosis > 30° or Kyphosis [ ] Osteoporosis / Pathologic Fractures [ ] Hip Subluxation / Dislocation / Coxa Arthrosis
Neurological	[ ] Seizures or lack of consciousness (Date of last episode: ________________) [ ] Hydrocephalus / Shunt [ ] Chiari II Malformation / Tethered Cord [ ] Spina Bifida / Spinal Cord Injury (Level: _______)
Medical	[ ] Indwelling Catheter [ ] Hemophilia or easy bruising [ ] Skin Breakdown / Decubitus Ulcers [ ] Uncontrolled Hypertension or Heart Condition
Behavioral	[ ] History of violence or self-harm

Section: Physician's Attestation

To my knowledge, there is no medical reason why this person cannot participate in supervised equestrian activities. However, I understand that LifeStriders will weigh the medical information above against existing industry precautions and contraindications.

I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) and LifeStriders staff in the implementation of an effective and safe equestrian program.

Medical Professional Name/Title: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: ____________

____

Signature: ______________________________ **Date:** ____________

License / NPI Number: ______________________________ **State:** ____________

Address: ______________________________

Phone: ______________________________