Please return this form by mail/fax to: Agape Headquarters:
PO Box 207, Cicero, IN 46034; Fax (317) 984-9103

PHYSICIAN'S RELEASE FORM FOR AGAPE

This form is **required** if: ❒ Participant has Down Syndrome OR; ❒ If one or more of the health questions of the Health History Form are 'Yes'.

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PARTICIPANT INFORMATION

Participant Name: __________________________ DOB: ____________ Participant Weight: ___________

Name of
Parent(s)/Guardian(s):_________________________________Phone:_____________________

PHYSICIAN'S REPORT

Medical	Normal	If not normal, please explain
Appearance and affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Upper Extremities		
Lower Extremities		

REQUIRED FOR PERSONS WITH DOWN SYNDROME
Annual physical examination should reveal no symptoms of AAL. *****NO INDIVIDUAL MAY RIDE WITH POSITIVE SYMPTOMS OF AAI***** **Annual physical examination for AAI: Negative** ______________ **Date of physical exam (must be within 1 calendar year)**__________________ **Doctor's Initials** ____________________

Jarring Toleration:

☐ YES ☐ NO For activities at the horse barn such as horseback riding, can the participant tolerate jarring?

If no, please explain limitations in detail:

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Agape will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Agape for ongoing evaluation to determine eligibility for participation.

PHYSICIAN'S SIGNATURE:

Date:

Physician's Name (please print):

Phone:

Address/City/Zip: