PHYSICIAN'S RELEASE FORM FOR AGAPE

Please return this form by mail/fax to Agape Headquarters:
24970 Mt. Pleasant Road, Cicero, IN 46034; Fax (317) 984-9103

This form and all the contents within are <u>required</u> for participating in mounted programs.

PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____ Participant Weight: _____
Name of Parent(s)/Guardian(s):_____Phone:_____
Diagnosis (if applicable): _____

If coming with a group, what is the group's name? _____

PHYSICIAN'S REPORT

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

REQUIRED FOR PERSONS WITH DOWN SYNDROME
Annual physical examination should reveal no symptoms of AAI. *X-ray NOT REQUIRED or accepted in place of annual physical exam* *****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 within the last calendar year 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: