2024

Medical

MEDICAL AUTHORIZATION

Patient Name: _____ **DOB:** _____

Patient Phone Number: _____

TO BE COMPLETED BY PATIENT'S MEDICAL PERSONNEL:

I, Dr. _____ (print name) release my patient,

_____ (print patient name), to participate in the following services:

Allowed Activities (check all that apply): ☐ **Ground Activities** ☐ **Riding astride a horse**

Additional disclosures are necessary for individuals with scoliosis, seizure, Down syndrome, and/or spinal cord injury.

Patient diagnosis: _____

Specific Limitations: _____

_____

_____

_____

_____

Given the above diagnosis and medical information, I state that said person is not medically precluded from participation in equine-assisted services. I understand BraveHearts will weigh all medical information against any precautions and contraindications. Therefore, I refer said person to BraveHearts for ongoing evaluation to determine further eligibility for participation in equine-assisted services.

Medical Personnel's Name: _____ MD DO NP PA

License/UPIN #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Medical Personnel's Signature: _____ **Date:** _____