Mane Stream

PO Box 305 • Oldwick, New Jersey • 08858
Tel: (908) 439-9636 • Fax: (908) 439-2338
Web: www.manestreamnj.org

Dear Health Care Provider:

Your patient is interested in participating at the Mane Stream. In order to safely provide services, our center requests you to complete the attached "Annual Medical History and Physician's Statement."

The Professional Association of Therapeutic Horsemanship International and the American Hippotherapy Association, Inc. have written guidelines pertaining to precautions and contraindications for individuals participating in equine related activities. Therefore, when completing the "Annual Medical History and Physicians Statement," please note if these conditions are present and to what degree. The following is a list of suggested precautions and contraindications:

Orthopedic:
Atlantoaxial Instability
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis
Ossoficans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Scoliosis
Spinal Instability/Abnormalities

Neurologic:
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other:
Age- under 2 years
Indwelling Catheters
Medications – i.e. photosensitivity
Poor endurance
Skin Breakdown

Medical/Psychological:
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

Precautions and Contraindications

The primary focus of any facility offering equine related services is to provide a safe and productive experience for all participants. The question that must be asked is "Will the benefit outweigh the risk?" The general rule is "do no harm."

A precaution is defined as a measure taken beforehand against possible danger, failure, etc. Participants with precautions may require modifications to their program, additional equipment, and always require re-evaluations at regular intervals to assure the effectiveness of participation.

A contraindication is a condition or symptom that makes equine related services inappropriate. Few contraindications are clear-cut. A contraindication may be permanent; meaning some activities may never be appropriate for certain participants due to safety or health concerns. A contraindication may also be temporary until the participant's health or condition improves. A participant may also begin with equine related services as

part of their program, but may find it no longer safe to include equine movement with the progression of his or her disability.

The following must be considered when deciding to include equines:

- Most equine related services inherently involve movement. If the movement will cause a decrease in the participant's function, an increase in pain, or generally aggravate the medical condition it may not be the intervention of choice.
- The essence of equine related services is the human-animal connection. If this interaction is detrimental to the participant or the equine, services may be contraindicated.
- Equine related services always presents the potential for a fall. Such a fall may cause a greater functional impairment than the participant originally had. The possibility of a fall should be given careful consideration and may lead to the informed decision.
- Working around equines (i.e. grooming, leading, etc.) involves risk. Even the well-trained equine is subject to its instinctive fight or flight responses. Horses are large, move quickly, and can be dangerous to the participant who is unable to respond appropriately.

Atlantoaxial Instability in Down Syndrome as Related to Equine Related Services

Potential participants and parents of potential participants should be aware of the inherent risks involved with equine related services for individuals diagnosed with Down syndrome and/or atlantoaxial instability. Mane Stream is guided by the recommendations of PATH International, AHA Inc., and Special Olympics, all recognized experts in the area of activities for people with disabilities.

There is evidence that 10-20% of individuals with Down syndrome suffer from Atlantoaxial Instability. Atlantoaxial Instability can be defined as instability, subluxation or dislocation of the joint between the first and second cervical vertebrae (atlantoaxial joint). Instability of the joint is generally due to poor muscle tone and ligament laxity that is common with Down syndrome.

A lax joint may begin to put pressure on the spinal cord resulting in the following **neurologic symptoms**:

- Change of head control-head tilt, torticollis/wry neck, stiff neck
- Change of gait- progressive clumsiness, toe walking or scissoring, falling, posturing
- Change of hand control- progressive weakness, fisting, change of dominant hand, increasing tremor
- Change of bladder function
- Change of bowel function
- Increase in muscle tone
- Fatigue

Neurologic signs always supersede radiographs and can be considered a contraindication.
Atlantoaxial Instability exposes individuals with Down syndrome to the possibility of injury if they participate in any activity the hyper-extends, radically flexes, or creates direct pressure on the neck or upper spine. This condition can occur spontaneously or be induced by injury that results from excessive anterior movement of the upper spine.

Although every precaution is taken at Mane Stream to make services as safe and as risk free as possible, there is always risk involved when working around or sitting on a horse. Even the quietest of horses are by nature unpredictable, thereby increasing the possibility of an injury. A fall from a horse, a sudden movement of the horse, or even the horse's normal stride/movement can create hyper-extension or hyper-flexion of the neck and upper spine.

PATH International requires that all potential participants with Down syndrome have a medical examination by a licensed physician including a complete neurological exam that shows no evidence of AAI or neurologic symptoms. This information must be noted on the Annual Medical History and Physicians Statement. Thereafter an annual examination from a physician or qualified medical professional stating that the participant's physical exam reveals no signs of AAI or decrease in neurologic function is required for continued participation in any equine related services at Mane Stream.

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ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

By providing this form to my or the participant's physician, I provide my consent for their disclosure of the information about the named participant required in this form to Mane Stream. Information is kept confidential.

Participant's Information

Participant's name: _____ Today's Date: _____
Address: _____
DOB: _____ Gender: M ____ F ____

Height: _____ **Weight**: _____ ***Physician's initials are required here*** _____
It is crucial that this information be truthful and accurate. To provide inaccurate information may jeopardize the safety of the participant and others.

Medical Summary

Primary diagnosis: _____ Cause if known:_____
Other diagnoses: _____
If Down Syndrome/AAI- result of yearly neurological exam/test for AAI: ❑Negative ❑Positive
Results/date of exam/test:_____
Recent surgical procedures or hospitalization: _____
Brief current medical condition: _____
Date of last tetanus: _____

Current Medications

Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____
Name: _____ Dose: _____ For treatment of: _____

Abilities

Assistive Aids (*please check all that currently apply to the client, or note history in space provided*):
_____ Orthotics/Splints/Prosthetics (*specify type*): _____
_____ Cervical collar/Abdominal binder/Other trunk supports (*specify type*): _____
_____ Wheelchair/Walker/Crutches (*specify type*):_____
_____ Other assistive aids: _____

Physical Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill that at this time* (**1**) *Beginning Skill requires moderate assistance from others* (**2**) *Moderate Ability requires minimal assistance from others* (**3**) *Mastered is performed independently*

_____ Head and neck control _____
_____ Unsupported sitting balance _____
_____ Unsupported standing balance _____
_____ Unsupported walking _____
_____ Upper extremity (arm) strength / movement _____
_____ Lower extremity (leg) strength / movement _____
_____ Fine motor (hand/finger) strength / movement _____
_____ Gross motor (whole body) coordination _____

ANNUAL MEDICAL HISTORY and PHYSICIAN'S STATEMENT

Cognitive Skills (*please rate the following skills using the scale provided*):

(**0**) *Not able to perform skill at this time* (**1**) *Beginning Skill requires moderate assistance from others* (**2**) *Moderate Ability requires minimal assistance from others* (**3**) *Mastered is performed independently*

_____ Alertness/Attention _____
_____ Ability to follow 1-step commands _____
_____ Ability to follow multiple-step commands _____
_____ Activity level / endurance _____
_____ Visual ability _____
_____ Expressive Language _____
_____ Language Comprehension _____
_____ Socialization skills _____

Precautions/Contraindications (*Please check all that currently apply to your patient and degree of involvement, or note history in space provided. Please note that the following conditions may be a contraindication to participation*):

_____ Allergies (*specify type*) _____
_____ Arthritis (*rheumatoid or osteo*) _____
_____ Asthma _____
_____ Atlanto-Axial Instability- positive X-ray or positive neurological exam _____
_____ Behaviors _____
_____ Blood clots, deep vein thrombosis, peripheral vascular disease _____
_____ Body temperature regulation problems _____
_____ Bone abnormalities (*osteoporosis, pathologic fractures*) _____
_____ Brain injury _____
_____ Communicable Diseases _____
_____ Contractures/limited ROM (*location*) _____
_____ Gastro-intestinal or naso-gastric, or tracheal tube _____
_____ Heart condition/abnormality _____
_____ Hypertension _____
_____ Joint/tendon laxity, subluxation, dislocation _____
_____ In-dwelling catheter _____
_____ Shunt _____
_____ Psychiatric condition (*type*) _____
_____ Respiratory complications (*type*) _____
_____ Seizures (*list type, frequency and duration*) _____
Date of last seizure: _____
_____ Skin integrity issues, skin breakdown, skin/decubitus ulcers _____
_____ Chiari II malformation, tethered cord (*include release date*) _____
_____ Scoliosis _____
Location & degree of curve: _____
_____ Spinal fusion or internal fixators (*specify area, type, vertebrae involved*): _____
_____ Other (*please specify*) _____

Physician's Statement

In my capacity as medical advisor, I consent to the participation of _____ *(Patient's full name)* in the horseback riding program and/or therapy services at Mane Stream. I certify that all of the information that I have given is accurate and represents a complete medical history.

Physician's name: _____ **Date:** _____
Address or stamp:

Physician's Signature: _____