



Freedom Hills Therapeutic Riding Program, Inc.
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www.freedomhills.org

This is an update form for your participant's physician. Attach a copy of the previous Participant's Medical History & Physician's Statement. A copy is on file in office. We will make you a copy upon your request.

Date: _____

Dear Health Care Provider:

Your patient, _____

has been participating in equine activities program at _____ and is due for an update of their medical status. Please review their previous medical history and provide an update of the information in the space below. Address occurrences over the past year including surgeries, illnesses hospitalizations, changes in medications, treatment, weight, or behavior. Please indicate current height/weight. For your reference, potential precautions/contraindications are listed on the reverse.

Diagnosis: _____

Height: _____ Weight: _____

Update Status:

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ Licence/UPIN Number: _____
