Raemelton Therapeutic Equestrian Center

Medical History & Physician's Statement

To be completed annually by a physician.
Return with student registration or fax to 419-756-6825

Student's Name ____________________________________ Date of Birth ________

Height __________Weight____________

Diagnosis/ Disability _________________________Date of onset ________________

AREAS	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Tetanus shot: Yes _____ No ______ Date _________

Seizures: Yes ____ No ___ if yes, what type _______ Date of last seizure ________

Please indicate if the patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Please complete both sides of this form