



Medical History & Physician Statement



Handi Kids
Recreation for Children with Disabilities

470 Pine Street, Bridgewater, MA 02324
Office: 508-697-7557
Main Office Fax: 508-697-1529

1. Patient Information

The following information must be completed and signed by a licensed physician in order for this child to participate in the Handi Kids Program. Physician's signature is required at bottom of page 3, bottom of page 4 (if applicable), and bottom of page 5 (if applicable)

Participant Name _____

DOB _____ / _____ / _____ Weight _____ Height _____

Diagnosis _____ Date of Onset _____

For Persons with Down Syndrome:

_____ Negative Cervical X-Ray for Atlantoaxial Instability X-Ray Date _____

_____ Negative for Clinical Symptoms of Atlantoaxial Instability

Current Medications _____

Are there any limitations and/or physical restrictions while this child is at camp? _____

List any dietary restrictions? _____

Record of past medical treatments _____

Please describe any other additional information that might help us to work with the participant _____

2. Immunizations

	<u>Date</u>	<u>Date</u>	<u>Date</u>
DPT _____	Polio _____	MMR _____	
TD _____	Measles _____	Tetanus Toxoid _____	
Lead _____	Mumps _____	Tuberculin _____	
Adult Type _____	Rubella _____	Other _____	

3. Medical History

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

Areas	Yes	No	Comments
Auditory _____			
Ear Infections _____			
Visual _____			Glasses? Yes _____ No _____
Speech _____			
Cardiac _____			
Chicken Pox _____			
Circulatory _____			
PVD _____			
Postural Hypotension _____			
Diabetes _____			
Hemophilia _____			
Pulmonary _____			
Asthma/COPD _____			
Mononucleosis _____			
Neurological _____			
Seizures _____			
Controlled _____			Last Seizure: _____
Hydrocephalus _____			
Shunt _____			# Revisions: _____
Sensory Loss _____			
Muscular _____			
Contractures _____			
Orthopedic _____			
Allergies – Hay Fever _____			
Allergies – Insects _____			
Allergies – Ivy Poisoning _____			
Allergies – Penicillin _____			
Allergies – Other _____			
Pain _____			
Learning Disability _____			
Mental Impairment _____			
Psychological Impairment _____			
Other Impairment _____			
Immunity _____			
Balance _____			
Skeletal Information _____			Explain Degree _____
Spinal Column Injury _____			
Subluxing Joints _____			
Dislocating Joints _____			
Laminectomy/Fusion _____			

4. Request Form for Dispensing Medication at Camp

THIS PORTION MUST BE FILLED OUT BY PARENT AND PHYSICIAN.

All medicines brought to Handi Kids must be in its original container. NO MEDICATION DISPENSED WITHOUT DOCTOR'S CONSENT.

I request and give my consent to the camp nurse to administer to my child _____, _____, _____ medication prescribed by the physician _____ for the period from _____ to _____.

Medication will be brought to the camp by me and labeled with the name of the child, name of medication, dosage and time to be administered (original label of the pharmacy).

Name of Medication _____ Dosage _____

Time to be given _____

Any special instructions for administering: _____

Name of Medication _____ Dosage _____

Time to be given _____

Any special instructions for administering: _____

Name of Medication _____ Dosage _____

Time to be given _____

Any special instructions for administering: _____

I give permission for my child to self-administer the medication noted above if the program nurse determines it is safe and appropriate. _____yes _____no

My child is allergic to bees and authorization is given to administer an antihistamine ____yes*** ____no

***All campers allergic to bees must come to camp with an epi-pen at all times.

Date _____ Parent/Guardian Signature _____

THIS PORTION MUST BE COMPLETED BY THE PHYSICIAN

The above named child is under my care and I agree that the medication(s) as described above be administrated as requested.

Date _____ Physician's Signature _____



If the child is participating in Therapeutic Riding, this page must be completed by the physician. If not, please stop here.

THERAPEUTIC RIDING INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions and contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Scoliosis
- Kyphosis
- Lordosis
- Joint Subluxation & Dislocation (especially hip)
- Osteoporosis
- Pathological Fractures
- Coxas Arthrosis
- Hetereotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses
- Atlanto-axial Instability
- Internal Spinal Stabilization Devices

Medical/Surgical

- Allergies
- Cancer
- Poor Endurance
- Recent Surgery
- Diabetes
- Peripheral Vascular Disease
- Varicose Veins
- Hemophilia
- Blood Pressure Control
- Serious Heart condition
- Stroke (Cerebrovascular Accident)

Neurologic

- Hydrocephalus/Shunt
- Spina Bifida
- Tethered cord
- Chiari II Malformation
- Hydromyelia
- Paralysis due to Spinal Cord Injury
- Seizure Disorder

Secondary Concerns

- Behavior Problems
- Age under two years
- Age two - four years
- Acute exacerbation of chronic disorder
- Indwelling Catheter
- Skin Breakdown
- Medication (i.e. side effects of photo sensitivity)
- Immunity

Physician's Riding Authorization (check one)

To my knowledge there is no reason why the above person cannot participate in supervised equestrian activities. However, I understand that the Therapeutic Riding Center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program, including hippotherapy.

Recommended Frequency : _____

Precautions: _____

I do not recommend horseback riding for the above patient

Physician's Signature _____ Date _____

Physician's Name _____ Phone _____

City _____ State _____ Zip _____