NDSU BISON STRIDES

2025 Medical Authorization Form
(Page 1 of 3; parent/guardian or participant completes)

Participant's Consent for Release of Medical Information

I hereby authorize: _____

(medical personnel or facility)

to release information from the records of _____ DOB: _____

(patient's name)

The information is to be released to NDSU Bison Strides Equine Assisted Services for the purpose of developing an equine activity program for the above-named participant. The information to be released includes:

- Attached Medical Authorization Form and signed Medical Personnel's Statement

This release is valid for one year and can be revoked, in writing, at my request.

_____ _____

Required participant signature or parent/guardian of dependent participant **Date**

Print name: _____

Relation to participant: _____

Please fax completed and signed Medical Authorization Forms (3 pages) to:

701-231-7590 *Attention: Bison Strides* or send to:

NDSU Bison Strides
Hultz Hall 100
Dept 7630, PO Box 6050
Fargo, ND 58108-6050

Questions please call 701-231-9611 or e-mail ndsu.bisonstrides@ndsu.edu

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2025 Medical Authorization Form
(Page 2 of 3; medical personnel completes)

Participant's Name:	DOB:	Height:	Weight:
Diagnosis:		Date of Onset:	
Medications:			
Seizure Type:	Controlled? Yes ___ No ___	Date of Last Seizure:	
Shunt Present? Yes ___ No ___	Date of Last Revision:		
Special Precautions/Needs:			
Mobility	Independent Ambulation? Yes__ No__	Assisted Ambulation? Yes__ No	Wheelchair? Yes __ No __

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/ Psychological			
Pain			
Other			

For participants with Down syndrome an ANNUAL certification from their physician that a neurologic and/or physical examination reveals no sign of atlantoaxial instability or decrease in neurologic function is required.

1. ANNUAL neurologic/physical exam for AAI/decreased neurologic function:
    a. ___ Positive ___ Negative Exam date: _____

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2025 Medical Authorization Form
(Page 3 of 3; medical personnel completes and signs)

Participant's Name: _____ DOB: _____

Please note potential Precautions and Contraindications for Equine-Assisted Services below

Orthopedic	Medical/Psychological
Amputation	Medications: i.e., Photosensitivity/Allergies
Atlanto-Axial Instability- includes neurologic symptoms	Animal Abuse
Coxa Arthrosis	Physical/ Sexual/ Emotional Abuse
Cranial Deficits	Blood Pressure Control
Heterotopic Ossification/ Myositis Ossificans	Dangerous to self or others
Joint Subluxation/dislocation	Exacerbations of medical conditions
Osteoporosis	Fire Setting
Pathologic Fractures	Heart Conditions
Spinal Fusion/Fixation	Hemophilia
Spinal Instability Abnormalities	Medical Instability
	Migraines
Neurologic	Post- Traumatic Stress Disorder
Hydrocephalus/ Shunt	Peripheral vascular disease
Seizure	Respiratory Compromise
Spina Bifida: Chiari II Malformation	Recent Surgeries
Tethered Cord	Substance Abuse
Hydromyelia	Thought Control Disorder
	Indwelling Catheters
	Poor Endurance
	Skin Breakdown

Please list any specific limitations not noted elsewhere on medical history:

I have reviewed the medical history and release my patient to participate in equine assisted services (EAS) at NDSU Bison Strides. I am aware and permit my patient to actively participate in the areas of EAS including: _____ Ground activities (not riding) _____Sitting astride and riding a horse. Given the participant's diagnosis and medical information on the previous pages, this person is not medically precluded from participation in EAS at NDSU Bison Strides in the activities indicated above. **I understand that NDSU Bison Strides will weigh the medical information given against the existing industry precautions and contraindications described by the Professional Association of Therapeutic Horsemanship International (PATH Intl**). Therefore, I refer this person to the NDSU Bison Strides for ongoing evaluation to determine eligibility for participation.

Medical Personnel's Name: _____ MD __ DO __ NP __ PA __ Other:_____

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

License/UPIN # _____

Office address: _____ City: _____ State: _____ Zip _____

Office phone: _____ Office fax: _____