

**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 [nds.bisonstrides@nds.edu](mailto:nds.bisonstrides@nds.edu)

**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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(Page 3 of 3; medical personnel completes and signs)**

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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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: \_\_\_\_\_

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

<b>Orthopedic</b>	<b>Medical/Psychological</b>
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
	Post- Traumatic Stress Disorder
<b>Neurologic</b>	
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