



RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____

DIAGNOSIS _____ DATE OF ONSET _____

**PLEASE INDICATE IF THE RIDER HAS A PROBLEM AND/OR SURGERIES IN ANY OF THE FOLLOWING AREAS:
PLEASE CHECK YES OR NO AND COMMENT.**

<i>FOR PERSONS WITH DOWN'S SYNDROME:</i>				YES	NO	DATE
NEGATIVE CERVICAL X-RAY FOR ATLANTOAXIAL INSTABILITY:						
NEGATIVE FOR CLINICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY:						
TETANUS SHOT:						
	YES	NO	CONTROLLED	DATE OF LAST SEIZURE		
SEIZURES:						
	YES	NO	COMMENTS			
MEDICATIONS:						
AUDITORY:						
VISUAL:						
SPEECH:						
CARDIAC:						
CIRCULATORY:						
PERIPHERAL VASCULAR DISEASE:						
VARICOSE VEINS:						
HEMOPHILIA:						
HYPERTENSION:						
SERIOUS HEART CONDITION						
STROKE:						
NEUROLOGICAL:						
HYDROCEPHALUS/SHUNT:						
SPINA BIFIDA:						
TETHERED CORD:						
CHIARI II MALFORMATION:						

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Neurological continued	YES	NO	COMMENTS
HYDROMYELIA			
PARALYSIS FROM SPINAL CORD INJURY			
ORTHOPEDIC:			
SPINAL FUSION			
SCOLIOSIS			
KYPHOSIS			
LORDOSIS			
HIP SUBLUXATION			
HIP DISLOCATION			
OSTEOPOROSIS			
PATHOLOGIC FRACTURES			
COXAS ARTHROSIS			
HETEROTOPIC OSSIFICATION			
OSTEOGENESIS IMPERFECTA			
CRANIAL DEFECTS			
SPINAL ORTHOSIS			
INTERNAL SPINAL			
STABILIZATION DEVICES			
LEARNING DISABILITY			
MENTAL			
PSYCHOLOGICAL			
ALLERGIES			
CANCER			
POOR ENDURANCE			
RECENT SURGERY			
DIABETES			
INDWELLING CATHETER			
INDEPENDENT AMBULATION			
CRUTCHES			
WHEELCHAIR			
PULMONARY			
MUSCULAR			
OTHER			

Physician's Name _____ Physician's Signature _____

Address _____ City _____

State _____ Zip _____

Phone _____ Date _____