Healing Reins must have the following for a participant with Down syndrome.

Path Int'l Standard: A18

Each participant with Down syndrome has:
1. An annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI)
2. The completed signed and dated physician statement available on-site

Neurologic signs of AAI always supersede radiographs. The presence of the neurological disorder must be evaluated annually by a physician and is a contraindication for mounted equine activities. The annual neurological examination must be done for all participants with Down syndrome even if the program system for updating participant information does not require a complete new set of forms each year. The participant with Down syndrome must have a written statement from the physician that the exam did not reveal AAI or focal neurologic disorder. This may be included on the medical clearance form or could be a separate document.

This certification of the absence of signs of AAI or decrease of neurologic function by the physician must be completed prior to starting mounted activities and an annual re-certification should be completed for continuing participants.

***Required for Down syndrome from Physician:**

Neurologic Symptoms of Atlantoaxial Instability: Present___Absent___Date____

***Please include an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) is required.**

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Physician's Statement

Given the diagnosis and the medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl center for ongoing evaluation to determine eligibility for participation.

Physician Printed Name: _____Office Name:_____

License/UPIN Number:_____ Circle: MD DO NP PA or Other_____

Address/City/State/Zip:_____Phone:_____

Physician Signature: _____**Date:**_____

Return to Healing Reins of Kentucky, Inc. PO Box 2027, Henderson, KY 42419
or horsesheal1@gmail.com.