

Rivendell ReCreation Center
12469 Warner Hill Road
South Wales, NY 14139
716-457-3365

A Not-for-Profit Corporation

PHYSICIAN'S RELEASE

PATIENT'S NAME: _____	DATE OF BIRTH: _____
PARENT/GUARDIAN: _____	
ADDRESS: _____	

DIAGNOSIS: _____
DATE OF ONSET: _____

BRIEF MEDICAL HISTORY:

NOTE: If diagnosis is Down's Syndrome, please send results of most current cervical x-ray. For riding purposes, the x-ray must be performed every two to three years.

PSYCHOLOGICAL _____
MAKE-UP: _____
MEDICATIONS: _____
VISUAL PROBLEMS: _____
SPEECH PROBLEMS: _____
AUDITORY PROBLEMS: _____
CIRCULATION PROBLEMS: _____
NEURO-SENSATION: _____
BALANCE: _____
COORDINATION: _____
SPASTICITY AND/OR RIGIDITY: _____