

# EQUESTRIAN PHYSICAL FORM

All Equestrian Studies students are required to turn in a Pre-participation Physical Examination PRIOR to any type of activities at The University of Findlay equestrian campuses. This includes being able to ride and earning credit for barn chores.

## **WESTERN RIDERS:**

You may mail these papers to the Western Farm prior to your arrival on campus, fax or scan them to Carol Browne (details below), or you may bring them with you on the first day of class. Please copy your papers before mailing them in case they are lost in the mail.

Western Equestrian Physicals  
14700 US Rt. 68  
Findlay, OH 45840

Carol Browne  
419-434-4656  
[brownec@findlay.edu](mailto:brownec@findlay.edu)  
419-420-1736 (Fax)

## **ENGLISH RIDERS:**

You may mail these papers to the English Farm prior to your arrival on campus, fax or scan them to Trisha Boutwell (details below), or you may bring them with you on the first day of class. Please copy your papers before mailing them in case they are lost in the mail.

English Equestrian Physicals  
11178 TR 201  
Findlay, OH 45840

Trisha Boutwell  
419-434-4859  
[trisha.boutwell@findlay.edu](mailto:trisha.boutwell@findlay.edu)  
419-434-4860 (Fax)

**These forms must be turned in BEFORE you will be allowed to ride any horse on campus (including your own) or earn credit for barn chores.**

A physical must be submitted each academic year.

## EQUESTRIAN PRE-PARTICIPATION PHYSICAL EXAMINATION

Full Name (First, Middle, Last):	Circle One: ENGLISH WESTERN BOTH
Date of Birth:	Gender:
Local Address (Where you will live for the school year – Dorm; Apartment, etc):	UF Student ID#:
UF Email Address:	Cell Phone:
Emergency Contact Name:	Emergency Contact Relationship:
Home/Cell Phone for Emergency Contact:	Home/Cell Phone for Emergency Contact:

### MEDICAL HISTORY

*Please answer the questions in as much detail as possible. Check appropriate box and comment on all yes answers.*

<u>Have you ever:</u>	<u>Y</u>	<u>N</u>	<u>Date/Comments</u>
▪ Had a physician deny or restrict your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Had any surgery (What & When?)	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>Have you ever had, or do you now have:</u>	<u>Y</u>	<u>N</u>	<u>Date/Comments</u>
▪ A severe viral infection (e.g. mono) in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Discomfort, pain, tightness, or pressure in your chest DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Dizziness DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Racing of the heart/irregular rhythm?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Test for your heart (ECG – echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Kawasaki disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Epilepsy/Convulsions/Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Asthma, wheezing/cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Loss of function or absence of any organ? (e.g. testicle, kidney etc. Please list which organ)	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Severe headaches or migraines?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Hearing loss or perforated eardrum? (Which ear?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Impaired vision? (Wear glasses/contacts/both?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Unequal pupils? (R or L larger?)	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Have you ever had, or do you now have:</b>	<b>Y</b>	<b>N</b>	<b>Date/Comments</b>
▪ Heat exhaustion or heat intolerance?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Use of weight loss meds, laxatives, self-induced vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Treatment for a mental health condition? (Condition, when, where treated)	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Frequent anxiety, depression, insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Been prescribed any medications by a mental health professional? ( <i>List medications</i> )	<input type="checkbox"/>	<input type="checkbox"/>	_____

**List ALL medications and/or supplements you are currently using (including over-the-counter medications and inhalers):** \_\_\_\_\_

List any allergies (medicine, bees etc.) \_\_\_\_\_

<b>Have you ever had:</b>	<b>Y</b>	<b>N</b>	<b>Date/Comments</b>
▪ Loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Concussion? ▪ How many concussions? (List number and year)	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Have you ever sprained/strained, dislocated, fractured (including stress fractures), broken, or had repeated swelling or other injuries to any bones or joints?**      **YES**        **NO**   

**Circle:**    Head                  Neck                  Face                  Chest                  Shoulder                  Upper arm  
                 Elbow                  Forearm                  Wrist                  Hand                  Fingers                  Back                  Hip  
                 Thigh                  Knee                  Shin/Calf                  Ankle                  Foot                  Toes

Please provide dates and explanations for all circled items: \_\_\_\_\_

**Do you have any other medical or physical condition not mentioned above?**  
YES       NO  \_\_\_\_\_



**I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO MY KNOWLEDGE. I CONFIRM THAT I HAVE DISCLOSED ALL PERTINENT INFORMATION TO THE BEST OF MY KNOWLEDGE.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_

## PHYSICAL EXAMINATION (To be completed by MD, DO, NP, PA only)

Date \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

<b>Medical</b>	<b>Nml</b>	<b>Abml</b>	<b>Comments</b>
Eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupils equal	<input type="checkbox"/>	<input type="checkbox"/>	_____
▪ Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes			
Cardiovascular			
Murmurs (auscultation, standing, supine, +/- Valsalva)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Simultaneous femoral & radial pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (males only)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Musculoskeletal</b>	<b>Nml</b>	<b>Abml</b>	<b>Comments</b>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wrist/hand/fingers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foot/toes	<input type="checkbox"/>	<input type="checkbox"/>	_____

**I certify that I have reviewed the history and examined the above student and I recommend:**  
 \_\_\_\_\_ Clearance for equine studies including horse riding, barn duties, and physical training with no limitations.  
 \_\_\_\_\_ Clearance pending further evaluation or testing. (Please explain) \_\_\_\_\_  
 \_\_\_\_\_ Clearance with specific limitations. (Please explain) \_\_\_\_\_  
 \_\_\_\_\_ Disqualified from competition. (Please explain) \_\_\_\_\_

Name of Examining Practitioner (Please print) \_\_\_\_\_

Practitioner's credentials \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Practitioner Signature \_\_\_\_\_

Date \_\_\_\_\_