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: _____