ATLANTO AXIAL X-RAY VERIFICATION FOR RIDERS WITH DOWN SYNDROME

NAME OF RIDER: ____

ADDRESS: ____

NAME OF PHYSICIAN: ____

TELEPHONE: ____

DATE OF X-RAY: ____

RESULT OF X-RAY: ____

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PHYSICIAN'S SIGNATURE: ______________________________ DATE: __________

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NOTE: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic X-ray for Atlantoaxial instability. This form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray.

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Date Received: __________