

# ATLANTO-AXIAL X-RAY VERIFICATION FOR RIDERS WITH DOWN SYNDROME

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone : \_\_\_\_\_ (home)

\_\_\_\_\_ (work) \_\_\_\_\_ (cell)

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of X-Ray: \_\_\_\_\_

Result: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**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 atlanto-axial instability. This form must be accompanied by a signed and dated statement from a qualified physician giving the date and result of the diagnostic X-Ray.