FREDERICTON THERAPEUTIC RIDING ASSOCIATION

PHYSICIAN PERMISSION AND ASSESSMENT FORM

NAME: _____

MAILING ADDRESS: _____

_____

TELEPHONE: Days _____ Evenings _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____
(M/D/Y)

DIAGNOSIS: _____

ONSET: _____

MEDICATION: _____

ALLERGIES: _____

PHYSICAL STATUS:

Mobility _____ Sitting Balance: _____

Coordination Upper Extremities _____

Lower Extremities _____

Speech _____ Hearing: _____

Vision _____ Seizures: _____

Neurosensation _____ Proprioception: _____

Incontinence _____ Other: _____

MENTAL STATUS:

Comprehension _____

Attitude Towards Disability _____

Anxiety or Depression _____

Other _____

Precautions _____ Limitations _____

Braces, Etc. _____ Purpose of Service _____

I hereby give permission for _____ to participate in *Fredericton Therapeutic Riding Association's* horseback riding program.

SIGNATURE OF PHYSICIAN _____

NAME OF PHYSICIAN (please print) _____

DATE: _____

Date Received: _____