Fredericton Therapeutic Riding Association

Physician Permission and Assessment Form

Physician Name: _____ Phone Number: _____

Office Address: _____

General Information

Participant Name: _____

Diagnosis: _____

Onset: _____

Medication: _____

Allergies: _____

Physical Status

Mobility: _____ Sitting Balance: _____

Coordination: Upper Extremities _____

Lower Extremities _____

Speech: _____ Hearing: _____

Vision: _____ Seizures: _____

Neurosensation: _____ Proprioception: _____

Incontinence: _____ Limitations: _____

Precautions: _____ Braces, etc: _____

Other: _____

Mental Status

Comprehension: _____

Attitude Towards Disability: _____

Anxiety or Depression: _____

Other: _____

I hereby give permission for the participant listed above to participate in the programs offered by the Fredericton Therapeutic Riding Association.

Signature of Physician

_____

Date

_____