



Physician's Approval Form

A Physician's Approval is required of any rider with a diagnosis.

Name _____ Date of Birth _____

Patient's Height _____ Patient's Weight _____

Occupation _____

Parent/Legal Guardian _____

Address _____
Street City State Zip

Diagnosis _____ date of onset _____

Medical History:

Surgical Procedures: _____

Psychological (include IQ where pertinent) _____

Medications: _____

Visual Impairments _____ Auditory Impairments _____

Speech Impairments _____ Circulation _____

Neuro-Sensation _____

Balance _____ Coordination _____

Spasticity and/or Rigidity _____

Braces _____ Assistive Devices _____

Seizures _____ Incontinence _____

In my opinion, this patient can receive riding instruction under appropriate supervision.

Precautions or Restrictions to therapeutic horseback riding _____

Physician's Name (print please): _____ Phone: _____

Address _____
Street City State Zip

**Physician's Signature: _____ Date _____

**Form must be signed by the Physician

(rev. 12.14)