Positive Strides Therapeutic Riding Center, Inc.

Physician's Prescription

Prescription for Equine Assisted Activities and Therapies

Client's Name_____

Parent/Guardian's Name_____

Phone/email_____

Precautions_____

_____

_____

Physician'sSignature_____Date_____

Physician's Printed Name_____

Address_____

Phone/email_____

To my knowledge there is no reason why_____cannot participate in supervised equestrian activities. However, I understand that Positive Strides, Inc will weigh the medical information above against the existing precautions and contraindications, which I have described.

Physician's Signature_____Date_____

Physician's Printed Name_____

Address_____

Phone/email_____