PHYSICIAN'S PRESCRIPTION

Prescription for Therapeutic Horseback Riding

Client/Patient's Name _____

Parent or Guardian's Name _____
Phone _____

Precautions _____
_____
_____

Physician's signature_____Date_____
Physician's Name (Please print)_____
Address_____
Phone_____

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

Physician's Name (Please print)_____
Physician's Signature _____
Address _____
Phone _____ Date_____