



PIONEER VALLEY THERAPEUTIC RIDING ASSOCIATION, INC.

PVTRA • P.O. Box 944 • Belchertown, MA 01007 • Telephone (413)668-8260 • A non-profit corporation with tax-exempt status

PHYSICIAN REFERRAL

Pioneer Valley Therapeutic Riding Association (PVTRA) provides horseback riding lessons for children and adults with disabilities. Instructors, licensed by the Commonwealth of Massachusetts and certified through North American Riding for the Handicapped Association (NARHA) are on site. PVTRA is a NARHA Premiere Accredited Center and follows its instructional and safety guidelines. Realizing that riding is a controlled risk activity, we use safety equipment, specially screened and trained horses, and trained volunteers.

Rider's Name: _____ Date of Birth: _____

Address: _____

Name of Parent/Guardian: _____

Height: _____ Weight: _____

Diagnosis* _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Side effects of medication(s): _____

Seizure Type: _____ Controlled: Yes No Date of Last Seizure: _____

Shunt Present: Yes No Date of Last Revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

**For those with Down Syndrome:*

AtlantoDens Interval X-rays, Date: _____ Result: _____

Precautions or Contraindications to Riding: _____

Please indicate current/past special needs in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that PVTRA will weigh the medical information above against the existing NARHA guidelines for precautions and contraindications.

Physician's Name/Title *(please print)* _____ Date: _____

Physician's Signature: _____

Address: _____

Phone: _____ License/UPIN Number: _____