

Miracles In Motion Application/Evaluation Form

Name _____ Date of Birth _____ Phone _____

Parent/Guardian _____

Address _____

E-Mail Address _____

Diagnosis _____

School Program: Level I _____ Level II _____ Level III _____ Other _____

Physician's Name _____ Address _____ Phone _____

Specialist Physician's Name _____ Address _____ Phone _____

PLEASE NOTE: Precautions and contraindications to therapeutic horseback riding do exist. Registration is based on a signed medical form and evaluation by Miracles in Motion team.

The following questions are designed to help us determine a student's functional level.

Height: _____ Weight*: _____ *weight limit is 200 lb.

Head Control: Is the applicant able to stabilize head/neck against a quick forward movement? Yes No

Sitting: Independently? Yes No How long? _____

With assistance? Yes No

Mobility: Crawls? Yes No Stands? Yes No

Walks with assistance? Yes No Device? _____

Walks independently? Yes No

Protective reactions: Can protect against loss of balance? Sitting? Yes No

Standing? Yes No

Communication: Verbal? Yes No Sign Language? Yes No _____ type?

Vision/Hearing: Describe impairment, if any: _____

Riding Experience: Yes No _____ How long?

SIGNED: _____