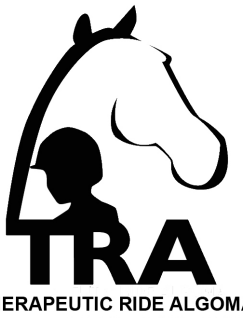

Therapeutic Ride Algoma- Application Form

Contact Details:

NAME OF APPLICANT:_____

NAME OF PARENT/GUARDIAN (if applicable):_____

APPLICANT'S DATE OF BIRTH: _____ AGE:_____

ADDRESS:_____

CITY:_____ POSTAL CODE:_____

TELEPHONE: (H)_____ (W) _____ (Cell) _____

E-MAIL:_____

Medical Information:

APPLICANT'S HEIGHT:_____

WEIGHT:_____

DIAGNOSIS (primary):_____

_____

DIAGNOSIS (secondary - if applicable):_____

_____

MEDICATIONS:_____

_____

ALLERGIES:_____

DOCTORS FOLLOWING APPLICANT:_____

_____

THERAPY RECEIVED AND GOALS:

PT_____

OT_____

ST_____

Other: _____

MOBILITY AND FUNCTION

Sitting/standing balance: _____

Walking: _____

Braces/Splints: _____

Mobility Aids used: _____

Wheelchair use: _____

Upper Extremities: _____

VISION:_____

HEARING: _____

SCHOOL ATTENDED (if applicable):_____

REASON FOR APPLICATION TO TRA:_____

_____

_____

OTHER RELEVANT INFORMATION/COMMENTS:_____

_____

_____

_____

_____

If referred by a professional (please circle all that apply) [physician] [educational] [PT] [OT] [ST] [Other]

If other, please explain:_____

_____

HOW DID YOU HEAR ABOUT TRA?_____

Form Completed by: _____Date: _____