



### Application Form for Waiting List

Date \_\_\_\_\_

Name \_\_\_\_\_

Parents or Guardian \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Disability \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_ Sex \_\_\_\_\_

**Does applicant use any of the following:** (check those applicable)

- \_\_\_\_\_ 1. Wheelchair
- \_\_\_\_\_ 2. Crutches
- \_\_\_\_\_ 3. Walker
- \_\_\_\_\_ 4. Braces
- \_\_\_\_\_ 5. Other \_\_\_\_\_

**Assist for transfer needed:**

- \_\_\_\_\_ 1. None
- \_\_\_\_\_ 2. Min
- \_\_\_\_\_ 3. Mod
- \_\_\_\_\_ 4. Max

Is Applicant incontinent? Yes \_\_\_\_\_ No \_\_\_\_\_

**Has/does applicant have trouble with the following:** (check those applicable)

- \_\_\_\_\_ 1. Hearing
- \_\_\_\_\_ 2. Sensation
- \_\_\_\_\_ 3. Speech
- \_\_\_\_\_ 4. Vision



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- \_\_\_\_\_ 5. Balance
- \_\_\_\_\_ 6. Circulation
- \_\_\_\_\_ 7. Seizures
- \_\_\_\_\_ 8. Coordination

School \_\_\_\_\_

Other Therapies \_\_\_\_\_

Days/Times available to ride \_\_\_\_\_