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Teacher Assessment

Adaptive Riding

Updated 4/11/2025

Participant Info

Participant Name: _____ Grade: _____

School: _____ Teacher: _____

Diagnosis/Disability: _____

Currently enrolled in: ☐ Occupational Therapy ☐ Physical Therapy ☐ Other: _____

Participant Limitations

Speech/Hearing: _____

Vision: _____

Mobility: _____

Adaptive/Medical Equipment: _____

Other (Please Describe): _____

Participant Goals

Goal 1: _____

Goal 2: _____

Participant Behaviors

Do they currently have a behavior plan? ☐ Yes (please attach) ☐ No

Behaviors: _____

Triggers: _____

Coping strategies or ways to redirect: _____

Signature: _____ Date: _____

Printed Name: _____