

**AMTRYKE® ASSESSMENT FORM (MUST BE FILLED OUT COMPLETELY BY THERAPIST)**

Request form, assessment form, and liability waiver are required for tryke Placement

Child's Name: \_\_\_\_\_

Ship To: \_\_\_\_\_ Attn: \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone #: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Special Consideration, i.e.: Leg length discrepancy, etc.

Desired Goal or Outcome:

**Arm Length and Inseam Length Measurements are Critical to Correct AmTryke® therapeutic tricycle selection. Please Complete. Measurements in inches.**

\*\*Arm Length (axilla to knuckles) Right: \_\_\_\_\_ Left: \_\_\_\_\_  
\*\*Leg Length (inner groin to bottom of shoe) Right: \_\_\_\_\_ Left: \_\_\_\_\_

AmTryke Model Requested: \_\_\_\_\_ AM-9 \_\_\_\_\_ AM-12 \_\_\_\_\_ AM-16 \_\_\_\_\_ All Terrain \_\_\_\_\_ 1402

**Adaptive Equipment needed: Circle accessories needed.** (check website [www.ambucs.org](http://www.ambucs.org), if you have questions concerning the accessories)

AM-9: Small or large bucket seat Vertical Hand Grips Wrist Wrap XS, S, M, L, XL

Toddler Footcups Pedal Block (each equals 1/2-inch) \_\_\_\_\_ Hand Wraps 1 or 2

AM-12, AM-16, All Terrain-(Seating Option: Bucket Seat or Saddle Seat)

Push Bar Wrist Wraps XS, S, M, L, XL Hand Wraps 1 or 2 Bench Seat

1400 Seatback(includes push bar, back, 2 laterals) 1400 Head Rest 1400 Hip Pad

Pedal Block (each equals 1/2-inch) \_\_\_\_\_ Medium or Large Foot-cups Knee separator

1402 ProSeries

Wrist Wraps XS, S, M, L, XL Hand Wraps 1 or 2 Bench Seat Bucket Seat

1400 Hip Pad 1400 Head Rest Knee separator

Are you the treating therapist for this child? Yes or No Are you the therapist at the Demo Site? Yes or No  
Therapist Name: \_\_\_\_\_

Demonstration Site Name: \_\_\_\_\_

(If not a Demo Site) Facility Name/Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Therapist Comments Concerning Child: \_\_\_\_\_

\_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return a copy of this completed form to: Walker AMBUCS™ ATTN:AmTryke PO Box 81 Marne, MI 49435

# AMTRYKE® THERAPEUTIC TRICYCLE WAIVER

**PURPOSE** The AmTryke® therapeutic tricycle was designed for children with disabilities. The hands, feet, or both power the tricycle. It allows freedom to travel, builds self-esteem, strengthens muscles, and improves motor coordination and range of motion while making exercise fun.

**Wish List** To be eligible for the National Wish List all three forms must be received by the Resource Center. The three forms are the Request Form, Assessment Form, and Liability Waiver. Once these forms are received, the child's name is placed on the list and will remain there until the funds are raised to purchase the AmTryke® therapeutic tricycle for the child. This may take some time, please be patient.

**STEERING OPTIONS** Initially, the child may have difficulty turning or changing directions. Encourage the child to go straight ahead, back up and slowly turn around. There are three steering options for the AmTryke® therapeutic tricycle. The tricycle comes out of the shipping boxes in the locked forward position. This is for shipping safety and also allows time for a new rider to build strength and control. On the front column of the tricycle you will find a steering pin with a large instruction tag attached. Read and follow the instructions to change the steering to twenty degree turning radius or free motion.

**CAUTION**  
*Fast speeds and sharp turns can cause the AmTryke® therapeutic tricycle to tip or turn over!  
Always wear helmet when riding AmTryke® therapeutic tricycle with adult supervision!*

AMBUCS™ members nationwide are dedicated to creating opportunities for mobility and independence for people with disabilities by performing community service, providing AmTryke® therapeutic tricycles to children with disabilities, and providing scholarships for therapists.

*The information contained in this service is not intended nor implied by National AMBUCS™, Inc. to be professional medical advice by National AMBUCS™, Inc.. Always seek the advice of your physician, therapist or other qualified healthcare provider prior to starting any treatment or with any question you may have regarding a medical condition. Nothing contained in this service is intended by National AMBUCS™, Inc. to be for medical diagnosis or treatment by National AMBUCS™, Inc., or on behalf of National AMBUCS™, Inc.*

*In no event shall National AMBUCS™, Inc., be liable for any direct, indirect, incidental, consequential, special, exemplary, punitive, or any other monetary or other damages, personal injury or property damages, fees, fines, costs, attorney fees or liabilities of any kind, arising out of or relating in any way to this service or use of the AmTryke® therapeutic tricycle, and/or content or information provided herein.*

**Child's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Print Legal Guardian Name:** \_\_\_\_\_

**Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Request form, assessment form, and liability waiver are required for tryke Placement

Walker AMBUCS  
P.O. Box 81  
Marne, MI 49435  
[www.walkerambucs.org](http://www.walkerambucs.org)  
[walkerambucs@yahoo.com](mailto:walkerambucs@yahoo.com)



WALKER CHAPTER

**REQUEST FOR AMTRYKE®  
THERAPEUTIC TRICYCLE APPLICATION  
(To be filled out by parent/guardian!)**



CHILD'S NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF REQUEST \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_ County \_\_\_\_\_

PARENT'S/GUARDIAN NAME: \_\_\_\_\_ Email: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SECONDARY CONTACT NAME: \_\_\_\_\_ PHONE \_\_\_\_\_

DIAGNOSIS OF CHILD: \_\_\_\_\_

TREATING THERAPIST'S NAME: \_\_\_\_\_ TITLE/FIELD: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOW DID YOU HEAR ABOUT THE AMTRYKE® THERAPEUTIC TRICYCLE? (CHECK ALL THAT APPLY)

\_\_\_\_\_ THERAPIST \_\_\_\_\_ WEBSITE \_\_\_\_\_ AMBUCS™ MEMBER \_\_\_\_\_ \*OTHER

\*IF OTHER PLEASE SPECIFY WHERE: \_\_\_\_\_

AMTRYKE® DEMONSTRATION SITE, GIVE NAME/STATE: \_\_\_\_\_

\*\*IS FINANCIAL ASSISTANCE NEEDED IN OBTAINING THE TRICYCLE? \_\_\_\_\_ YES \_\_\_\_\_ NO

\*IF YES, HOW MUCH CAN YOU PAY? \_\_\_\_\_

I AGREE TO "RECYCLE" THE TRYKE FOR USE BY ANOTHER CHILD? \_\_\_ YES

**TELL US ABOUT YOUR CHILD:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If possible including a photo of your child will help us to obtain a sponsor for your child's AmTryke® tricycle.**

*I give my permission for my child's picture and personal information to be used in AMBUCS™ materials to help in obtaining a sponsor for the AmTryke® therapeutic tricycle.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*AmTryke® therapeutic tricycles are distributed based on available funds and need, and individual placements of AmTryke® therapeutic tricycles are at the discretion of the local chapters.**

Please mail or fax this application to: Walker AMBUCS™

ATTN: Amtryke

PO Box 81 Marne, MI 49435

AMTRYKE REQUEST, ASSESSMENT FORM AND PARENT/GUARDIAN WAIVER MUST ALL BE RECEIVED IN ORDER TO PROCESS YOUR REQUEST.