PARTICIPANT'S APPLICATION & HEALTH HISTORY

Hope for Horses
Therapeutic Riding

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Parent(s)/Legal Guardian(s): _____

Caregivers: _____

Phone: _____

Employer/School: _____ Phone: _____

Address: _____

Referral Source: _____ Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____

_____

_____

_____

_____

Describe participant abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding, seizures, shunts)_____

_____

_____

_____

PHYCHOSOCIAL FUNCTION (e.g.,work/school, including grade, leisure interests, relationships - family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

_____

_____

GOALS: (What are some life/social, physical and mental or cognitive goals for the participant?)

_____

_____

_____

_____

_____

Signature: _____ Date: _____

PHOTO RELEASE: I DO ☐ DO NOT ☐ consent to and authorize the use and reproduction by

_____ (center) of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian (Signed in the presence of center staff)

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

To be completed by medical personnel ONLY

Hope for Horses
Therapeutic Riding

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis(es): _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____ Special Precautions/Needs: _____

_____

Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐Present ☐Absent

Please indicate current or past special needs in the following systems/areas, including surgeries.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the Hope 4 Horses Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the KISS Horse Center/Hope 4 Horses for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____Phone:_____