Participant's Application & Health History

GENERAL INFORMATION

Participant:_____

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

Address:_____

Phone: _____ Email: _____

Alternate #:_____

Employer/School:_____

Address:

_____

Phone:

_____

Parent/Legal Guardian:
_____Phone:_____

Caregiver:

_____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 your 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)*

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

GOALS *(i.e., why are you applying for participation? What would you like to accomplish?)*

_____
_____
_____
_____
_____

Signature:_____ Date: _____

PHOTO RELEASE

I ☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by Amy's Wish With Wings 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

Participant's Consent for Release of Information

I hereby authorize:

(person or facility)

_____

to release information from the records

(participant's name)

of:_____DOB:_____

The information is to be released to:

(center or therapist's name)

_____

For the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

☐ Medical history

☐ Physical therapy evaluation, assessment and program plan

☐ Speech therapy evaluation, assessment and program plan

☐ Mental health diagnosis and treatment plan

☐ Individual Habilitation Plan (IHP)

- [ ] Classroom Individual Education Plan (IEP)
- [ ] Psychosocial evaluation, assessment and program plan
- [ ] Cognitive-behavioral management plan
- [ ] Other

:_____

This release is valid for one year and can be revoked, in writing, at my request.

Signature:_____
Date:_____

Print Name:_____

Relationship to Participant: _____

Please send materials to:

_____

_____

_____

_____