Adaptive Riding Program
Participant's Application and Health History

GENERAL INFORMATION

Participant:_____
DOB:_____ Age:_____ Height:_____ Weight:_____ Gender:_____
Home Address:_____
Mailing Address:_____
Phone:_____ Alt Phone:_____
Email: _____
Employer/School:_____
Address:_____
Phone: _____
Parent/Legal Guardian: _____
Caregivers:_____
Address (if different from above): _____
Phone: _____
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:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			
Emotional/Mental			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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

_____
_____
_____
_____
_____

Describe your (participant's) 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)

_____
_____
_____
_____
_____

PHOTO RELEASE

I (participant) ___ DO
I (participant) ___ DO NOT

Consent to and authorize the use and reproduction White Horse Equine Assisted Services, LLC of any and all photographs and any other audio/visual materials taken of me (participant) for promotional material, educational activities, exhibitions or for any other user for the benefit of the program.

Printed Name: _____
Participant Signature: _____ Date: _____

Parent/Legal Guardian Printed Name: _____
Parent/Legal Guardian Signature:_____ Date: _____

Participant Riding Time and Day Policy:

I hereby confirm that _____ (rider's first and last name) will ride each Sunday at _____ PM (riding time). If the rider no call or no shows 3 times, their riding time will be given to another rider on the waitlist.

I _____understand and agree to this participant policy.

Printed Name: _____
Participant Signature: _____ Date: _____

Parent/Legal Guardian Printed Name: _____
Parent/Legal Guardian Signature:_____ Date: _____

About the Instructor:

Elizabeth has been a Certified Therapeutic Riding Instructor since 2016, working with both individuals and groups helping them to build strength and achieve their goals. Elizabeth also works as an Applied Behavioral Analysis professional specializing in Autism Spectrum Disorder. Elizabeth incorporates ABA practices within her teaching to help her students get the most out of their adaptive riding lessons and feel confident in what they are learning. Elizabeth's philosophy of teaching is to create and execute a safe and enjoyable lesson that teaches her students in a way that makes sense to them. "Each student learns differently, and I want to ensure I am teaching to the needs of the rider. I want to create an environment where my students will be excited to learn and express their abilities and talents, as well make small achievements along the way".

Instructor Information:

Elizabeth Davis
Email- whitehorseequineservices@gmail.com
Phone Number- 317-809-2877
Certified Therapeutic Riding Instructor

Participant's Medical History and Physician's Statement

(This statement needs to be signed off by the participant's current physician)

Participant: _____ DOB: _____ Height:_____ Weight:____
Address: _____
Diagnosis: _____ 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: _____
Mobility: Independent Ambulation Y N Assisted Ambulations 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. These conditions may suggest precautions and contraindications to equine activities.

	Yes	No	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 services and activities. I understand that the PATH Intl. Certified Instructor (Elizabeth Sadler Davis) will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to this PATH Intl. Certified Instructor for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone: _____ License/ UPIN Number: _____