THERAPEUTIC RIDING

PARTICIPANT'S APPLICATION & HEALTH HISTORY GENERAL INFORMATION

Client Name:_____

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

Address:_____

Phone:_____ Email:_____ Alternative #:_____

Employer/School:_____

Address:_____

Parent/Legal Guardian:_____

Address (if different from above):_____

Phone:_____

Referral Source:_____

Phone:_____

How did you hear about the program?_____

HEALTH HISTORY

Diagnosis:_____ Date of Onset:_____

Allergies:_____

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

	Y	**N**	**Comments**
Vision	___	___	_____
Hearing	___	___	_____
Sensation	___	___	_____

	Y	N	Comments
Communication	___	___	_____
Heart	___	___	_____
Breathing	___	___	_____
Digestion	___	___	_____
Elimination	___	___	_____
Circulation	___	___	_____
Emotional/Mental	___	___	_____
Behavioral	___	___	_____
Pain	___	___	_____
Bone/Joint	___	___	_____
Muscular	___	___	_____
Thinking/Cognition	___	___	_____

PAST SURGICAL PROCEDURES: _____

_____

_____

USE OF ADAPTIVE ACCESSORIES (i.e., AFOs, walkers, cane, hand grips): _____

_____

_____

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

_____

_____

_____

OT:_____

PT:_____

SPEECH:_____

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)

_____

_____

_____

_____

PSYCHOLOGICAL FUNCTION (e.g., work/school including grade completed, leisure interests, relationships-family structure, support system, 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 The Stables at Le Bocage of any and all photographs and any other audio/visual materials taken of _____ for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_____ Date:_____

Client, Parent or Legal Guardian

Witness:_____ Witness:_____

Print Name:_____ Print Name:_____

WARNING:

Under Louisiana Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risk of equine activities, pursuant to La. R.S. 9:2795.3.

NOTE: All participants, volunteers, and personnel are required to wear protective headgear while mounted. This headgear must be an ASTM-SEI approved helmet, an alternative helmet that meets the PATH guidelines for Alternative Helmet Use may be used (See, Guidelines found in the Standards manual, page ____).

COVID-19/CORONAVIRUS:

Reins of Hope Therapeutic Riding Center is committed to ensuring the safety of our riders and volunteers. We are implementing certain safety guidelines at the recommendations of the Center of Disease Control (CDC), Louisiana Department of Health (LDH) and Professional Association of Therapeutic Horsemanship International (PATH). *Please initial the following.*

____ I understand that there is a possibility of contracting COVID-19 despite infection safety control measures taken by Reins of Hope Therapeutic Riding Center

____I will not hold Reins of Hope liable in the event that the I contract COVID-19 that can be traced back to Reins of Hope Therapeutic Riding Center

Volunteers are welcome to wear a mask, but it is not required

Signature: _____ Date: _____

How did you hear about the program? _____

_____