



The Equestrian Therapy Program

Student's Information & Health History

Student's Name: _____

Parents/Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail: _____

Parent/Guardian address (if different from above): _____

Caregiver: _____ Phone: _____

Please contact named individual in the event of a cancellation if different from student's phone number.

Name: _____ Phone: _____

Students Disability: _____ DOB: _____ Weight: _____ Height: _____

Gender: M F Date of Onset: _____ Secondary Diagnosis: _____

Health History

Please indicate if the student has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

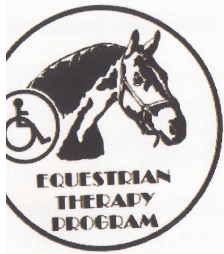
Areas	Yes	No	Comments
Hearing			
Vision			
Communication			
Balance			
Coordination			
Spasticity/Rigidity			
Muscular			
Neurological			
Orthopedic (Bone/Joint)			
Heart/Circulation			
Sensation			
Pain			
Incontinence			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
Other			

Mobility: **Independent Ambulation:** Yes No **Crutches:** Yes No **Braces:** Yes No **Wheelchair:** Yes No

Describe any medical condition requiring special precautions or treatment and medications and dosage:

Please Sign that the above information is accurate to the best of your knowledge.

Signature: _____



The Equestrian Therapy Program

Emergency Medical & Consent Form

Students Name: _____

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

Physician's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Medical Facility: _____

Health Insurance Co. _____ Policy # _____

Person who is authorized to give temporary assistance or care in the absence of parent or guardian:

Name: _____ Phone: _____ Relation: _____

Consent

In case of medical emergency, the undersigned authorizes *Equestrian Therapy Program* to provide such medical assistance as they determine to be necessary,

I hereby give my consent, in the event that all reasonable attempts to contact me have been unsuccessful, to the administration of any treatment deemed necessary by or the transfer to the student to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity to such surgery and are obtained prior to the performance of such surgery.

Date: _____ Consent Signature: _____
(Student if over 18, Parent/Legal Guardian)

Witness: _____
(Parent/Legal Guardian)

Participants under age (18) must have this form signed either by both natural parents, or by the sole parent having legal custody, or by the participant's legal guardian.

Non Consent

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property or The Equestrian Therapy Program.

Parent or Legal Guardian will remain on site at all times during equine assisted activities.

In the event emergency treatment/aid is required, I wish the following procedure to take place.

Date: _____ Non-Consent Signature: _____
(Student if over 18, Parent/Legal Guardian)

Witness: _____
(Parent/Legal Guardian)

Participants under age (18) must have this form signed either by both natural parents, or by the sole parent having legal custody, or by the participant's legal guardian.