MANE STRIDE

An Equine Assisted Therapeutic and Riding Program

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ E-mail: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Address (If different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about our program(s)? _____

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/Menta			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Cognition/Thinki			
Allergies			

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

_____

_____

_____

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

PHYSICAL FUNCTION (i.e. mobility skills such as transfer, walking, wheelchair use, etc.)

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (i.e. 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 in this program? What would you like to accomplish for your child?)

_____

_____

_____

Signature: _____ Date: _____

Photo Release □ I Do □ I Do Not consent to and authorize the use and reproduction by Mane Stride 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 center.

Signature: _____Date:_____

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