



For Office Use Only

Date received _____

Communication log:

Participant Application

To be completed by the participant, parent/legal guardian,
or Small Miracles staff via phone.

Participant: _____ Date of Birth: _____

Height: _____ Weight: _____ Gender: _____

Complete Address: _____

Phone: _____ Alternate #: _____ Email: _____

Parent/Legal Guardian: _____ If Guardian, do they have legal custody? _____ (Must have guardianship papers)

How did you hear about the program? _____

Diagnosis & explanation: _____

Please indicate current or past difficulties in the following systems/areas

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart/Circulation			
Breathing			
Digestion			
Elimination			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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Participant: _____

Any problems in the following areas? If so, please comment/explain:

Bleeding: _____

Spine: _____

Scoliosis: _____ Degree: _____

Seizures: _____

Type: _____ Frequency: _____

Duration: _____ Aura: _____

Describe motor activity during seizure: _____

Describe behavior after seizure: _____

What medication(s) is the participant currently taking, including over-the-counter medications? _____

Please describe your prior therapeutic riding or horseback riding experience (if any): _____

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

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving, sit with assistance etc): _____

SOCIAL (i.e. 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?): _____

OTHER (notes or concerns please indicate if scholarship is anticipated): _____

This form was completed by: _____

Please attach additional pages if desired.
Feel free to enclose a photograph for your file.

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