

Participant Application

For office use on	y
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To be completed by the participant, parent/legal guardian.

Date form received	

Participant:					
Date of Birth	H	eight:	Weight:	(Gender:
Complete Address:					
Phone:	Alterna	ate #:	I	Email:	
Parent/Legal Guardian: _					
If Guardian, do they have	legal cus	tody?		(Must have §	guardianship papers)
How did you hear about t	the progra	am?			
Diagnosis & explanation:					
Please	n indicato	current or pact	difficulties in th	o following sw	stoms/areas:
	Y	current or past	difficulties in th	Comments	
Vision					
Hearing					
Sensation					
Communication					
Heart/Circulation					
Breathing					
Digestion					
Elimination					
Emotional					
Behavioral/Anger					
Pain					
Bone/Joint					
Muscular					
Thinking/Cognition					
Allergies					

Participant: Any problems in the following areas? If so, please comment/explain:					
Spine:					
	Degree:				
Seizures:					
Type:	Frequency:				
Duration:					
Describe motor activity during seizure: _					
Describe behavior after seizure:					
What medication(s) is the participant curre	ently taking, including over-the-counter medications?:				
Please describe your prior equine-assisted	activities and therapies experience (if any):				
	sfers, walking, wheelchair use, driving, sit with assistance etc):				
SOCIAL (i.e. work/school including grade c	completed, leisure interests, relationships-family structure, s/concerns, etc.):				
GOALS (i.e. Why are you applying for part	ticipation? What would you like to accomplish?):				
OTHER (notes or concerns please indicate	if scholarship is anticipated):				
This form was completed by:					

^{*}Please attach additional sheets of paper if desired *Feel free to enclose a photograph for your file.