

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

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

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Employer/School Name: _____

Parent/Legal Guardian: _____

List Phone Numbers and whose number it is, if other than Participant:

Home #: _____ If not Participant's #, whose is it? Name: _____

Work #: _____ If not Participant's #, whose is it? Name: _____

Cell #: _____ If not Participant's #, whose is it? Name: _____

Other #: _____ If not Participant's #, whose is it? Name: _____

Email Address: _____ Whose? _____

How did you hear of our program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

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

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What medications are you currently taking, including over-the-counter medications?

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

Physical Function (e.g. Ambulation, motor skills, balance, strength, tone, vision):

Cognition & Processing (e.g. Attention, touch/sensation, memory, speech & language, sensory integration, learning disabilities, developmental delays):

Psychological, emotional, behavioral, social issues (e.g. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fear/concerns, etc):

Goals (i.e. Why are you applying for participation? What would you like to accomplish?)

Do you have previous riding experience? If so, please describe:

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**Participant's Medical History and Physicians
 Statement**

Participant: _____ DOB: _____ Height: ____ Weight: ____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
 Shunt Present: Y N Date of Last Revision: _____
 Special Precautions/Needs: _____

 Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
 Braces/Assistive Devices: _____
 For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + --
 Neurological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special need in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective activity program.

Name/Title: _____ MD DO NP PA Other: _____
 Signature: _____ Date: _____
 Address: _____
 Phone: (____) _____ License/UPIN Number: _____

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Permission to photograph

I, _____, give my permission to REACH 4A Star Riding Academy
(Parent or Guardian)
to reprint or publish those pictures in literature about _____,
(Participant)
the REACH 4A Star Riding Academy program, or other articles of a “positive” nature.

I reserve the right to view any and all photographs of _____ that REACH
(Participant)
4A Star may wish to utilize and to “pull any photograph” that I do not wish to be shown or
viewed by others.

REACH 4A Star has assured me that _____ photos will not be used in
(Participant)
anyway to exploit, solicit money or sympathy.

By completing this form, I understand that I am agreeing to the terms above.

Participant

Date

Parent or Guardian

Date

Arena Director

Date

Authorization for Emergency Medical Treatment Form

___Participant

___Staff

___Volunteer

Name: _____ DOB: _____ Phone: _____
Address: _____
Physician's Name: _____ Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize REACH 4A STAR RIDING ACADEMY to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Volunteer, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during Special Olympics Program activities. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____
Volunteer, Parent or Legal Guardian

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