Rider's Application & Health History

CONTACT INFORMATION:

Name of rider: _____

Address_____City:_____Zip:_____

Phone Number:_____ E-Mail Address:_____

Date of Birth: _____ Height: _____ Weight: _____ Gender: Select one

Name of Parent/Guardian:_____

Emergency Contact Information: _____ Phone:_____

HEALTH HISTORY:

Diagnosis: _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

Tetanus Shot: Yes: ☐ No:☐ Date: Click or tap to enter a date.

Seizure Type: _____ Controlled: _____ Date of Last Seizure

Medications: _____

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

**** Only For Persons with Down Syndrome***

Cervical X-ray for Atlantoaxial Instability: Positive:☐ Negative:☐ X-Ray Date:

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: Yes ☐ No ☐ Crutches: Yes ☐ No ☐ Braces: Yes ☐ No ☐

Wheelchair: Yes ☐ No ☐ Please indicate any special precautions: _____

MEDICATION:_____

Has your child experienced a seizure within the last year, please obtain a doctors sign off for riding.

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Special Spirit Inc Therapeutic Riding Center will weigh the medical information above against the existing precautions and contradictions. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) _____

Physician Signature _____Date _____

Address _____ City _____ State Zip _____

Phone _____

PHOTO RELEASE

I ❑ DO ❑ DO NOT

consent to and authorize the use and reproduction by Horses & Horizons Therapeutic Learning Center, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, website, Facebook, or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Please submit filled out form to: info@specialspirit.org