ARIZONA HORSERIDING ADVENTURES™

Participant's Application & Health History

GENERAL INFORMATION

Participant:_____ DOB_____

Age: _____ Grade: _____ Height: _____ Weight: _____ Gender: M F

Address _____ City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone: _____ Alternate Phone: _____

Email Address _____ School _____

Parent/Legal Guardian _____ Phone Number_____

Emergency Contact:_____ Relationship_____Phone_____

Referral Source_____ Phone (if applicable)_____

How did you hear about Arizona Horseriding Adventures?_____

HEALTH HISTORY

Diagnosis:_____ Date and age of onset:_____

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

	Yes	No	Comments
Vision			
Hearing			
Speech			
Communication			
Cardiac			
Circulatory			
Pulmonary			
Muscular			
Orthopedic - Skeletal			
Scoliosis Degree %			
Learning Disability			
Mental Impairment			
Emotional Health			
Behavioral			
Bone/Joint			
Thinking/Cognition			
Allergies			
Elimination			
Other			

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MOBILITY:

Independent Ambulation: (Student walks independently) Yes____ No____ Leg Braces: Yes____ No_____

Uses Crutches or a Cane: Yes_____ No_____ Wheelchair: Yes____ No_____

Please indicate any special precautions_____

_____

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

_____

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

PHYSICAL FUNCTION (Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)_____

_____

PSYCHO/SOCIAL FUNCTION (Work/school including current grade or grade completed, leisure interests, support systems, companion animals, fears/concerns, etc.): _____

_____

_____

GOALS (Why are you applying for participation?): What would you like to accomplish or see your child accomplish with this program?_____

_____

_____

Signature:_____ **Date:**_____

PHOTO RELEASE: **I DO_____** **I DO NOT_____**

Consent to and authorize the use and reproduction by ARIZONA HORSERIDING ADVENTURES of any and all photographs and any other audio/visual materials taken of me or my child for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature_____ Date_____

PERSONS WITH DOWNS SYNDROME: THIS BOX MUST BE COMPLETED IN ORDER TO PARTICIPATE.

Cervical X-ray for Atlantoaxial Instability: Positive_____ Negative_____ X-ray Date_____