

**2012 WINSLOW THERAPEUTIC CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY**

(This information must be updated annually)

For the purposes of grants and other funding we request that you fill out ALL information in this packet.

PARTICIPANT NAME _____ DATE _____

DOB _____ AGE _____ HEIGHT _____ WEIGHT _____ GENDER _____ ETHNICITY _____

ADDRESS _____

EMAIL _____ HOME PHONE _____ CELL _____

EMERGENCY CONTACT NAME _____ PHONE NUMBER _____

EMPLOYER/SCHOOL _____ PHONE NUMBER _____

PARENT/LEGAL GUARDIAN _____ PHONE NUMBER _____

ADDRESS (if different from above) _____

HOW DID YOU HEAR ABOUT WINSLOW _____

HEALTH HISTORY

DISABILITY: PRIMARY _____ SECONDARY _____

Please indicate current or past problems in the following areas:

	Y	N	Comments
VISION			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMINATION			
CIRCULATION			
EMOTIONAL			
BEHAVIORAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITIVE			
ALLERGIES			
SEIZURES			
OTHER, please describe			

PLEASE LIST ALL MEDICATIONS TAKEN AND FOR WHAT PURPOSE

MEDICATION	TAKEN FOR

***Riders with Down Syndrome are required to have an Atlantoaxial Verification release signed by a physician.**

*** There is a rider weight limit of 225 lbs.**

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Functional Status	Independent	Some Assistance	Dependent
Sitting			
Standing			
Walking			
Wheelchair			
Dressing			
Toileting			
Feeding			

Language: Verbal _____ Sign _____ Gestural _____ Augmentative _____

Grade Level _____ Math _____ Reading _____

Explanation of Conditions/Diseases Checked _____

Social Development (i.e., work/school, leisure interest, etc.) _____

What form of behavior modifications do you use, if any? _____

LIABILITY RELEASE _____ (RIDER'S NAME) would like to participate in the Winslow Therapeutic Riding Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby intend to be legally bound, for myself, my heirs and assigns, executors and administrators, waive and release all claims for damages against Winslow Therapeutic Riding Unlimited, Inc. its Board of Directors, Instructors, Therapists, Aids, Volunteers, and Employees for any and all injuries and losses, I/my child/my ward may sustain while participating in the Winslow Program.

Date _____ PRINT NAME _____

CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE _____

PHOTO RELEASE (optional): I HEREBY CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY Winslow of any and all photographs and any other material, educational activities, exhibitions or for any other use the benefit of the program.

Date _____ CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Winslow Therapeutic Riding Unlimited, Inc. to:

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

Client/Rider's name _____ Phone: _____

Address _____

In the event I cannot be reached:

1. Contact _____ Phone: _____

2. Contact _____ Phone: _____

Physicians name _____ Phone _____

Preferred medical facility _____

Health Insurance Company _____ Policy number _____

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 below is unable to be reached.

Date _____ Consent signature _____

Print name _____ Phone: _____

Address _____