2011 WINSLOW THERAPEUTIC CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY
(This information must be updated annually)

PARTICIPANT NAME_____ DATE_____

DOB_____ AGE_____ HEIGHT_____ WEIGHT_____ GENDER_____

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_____ Augmenative_____

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 materiel, 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_____