

**WINSLOW THERAPEUTIC RIDING CENTER
PARTICIPANT'S APPLICATION AND HEALTH HISTORY UPDATE**

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.



If you have **not** had any changes to your current health or medications, please fill out this condensed update.
If you **do** have any changes, you are required to fill out a new Participant Application AND Physician Release.
***Participants with Down syndrome are required to have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI).**

PARTICIPANT NAME _____

AGE _____ HEIGHT _____ WEIGHT _____ Best number to contact for schedule changes, etc.: _____

Can we text you with changes, etc.? YES _____ NO _____ If yes, cell phone for text _____

Email address: _____ (I would like to be added to your e-mail list)

Cancellation policy: Winslow requires 24 hour cancellations for all lessons. Failure to do so will result in a \$25.00 charge. _____ Initial

Bad Weather: Classes will only be cancelled in the event of dangerous or threatening weather. To determine cancellations you can call Winslow directly at 845-986-6686. If we have not been able to reach you in the event we need to close there will be a message on our main voicemail. _____ Initial

Late Participant Policy: It is important for the participant to arrive 5 minutes prior to the scheduled riding time. If a client is more than 15 minutes late to a lesson, Winslow cannot guarantee he/she will be able to ride. Horses will be untacked and volunteers will be released 15 minutes after the scheduled start time of the class as well as the participant will be charged full lesson fee. If a Winslow instructor is running late your full lesson time will still be granted. _____ Initial

LIABILITY RELEASE _____ (PARTICIPANTS 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 _____

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CONFIDENTIALITY AGREEMENT:

I agree to respect and observe privacy and confidentiality of the participants, volunteers and personnel of Winslow Therapeutic Riding Center and not to discuss or disclose any sensitive information about any person or their family.

Participants Name: _____ Date: _____

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.

DO CONSENT DO NOT CONSENT

Date _____ CLIENT, PARENT, GUARDIAN, CAREGIVER SIGNATURE _____

RESPONSIBLE PARTY FOR BILLING:

Name _____ (Participants name) _____

Mailing address _____ City _____ State _____ Zip _____

Phone _____ Cell phone _____ Office phone _____

Signature _____ Relationship to rider _____

I hereby confirm that there are *no* changes to my health history and/or medications since 2016.

Client/Guardian Signature: _____ **Date:** _____

Print name: _____

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

WINSLOW THERAPEUTIC RIDING CENTER PARTICIPANT'S APPLICATION AND HEALTH HISTORY UPDATE

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ORANGE COUNTY COMMUNITY DEVELOPMENT PROGRAM PROGRAM PARTICIPATION INCOME SURVEY FORM - LIMITED CLIENTELE

Facility Name: _____

Program Number: _____

Date: _____

Facility Address: _____

Enrollment Date: _____

Number of Family Members Enrolled in Program: _____

Participant's Address (Residence): _____

SECTION I: INCOME

For statistical purposes only, in the chart below, please circle the number of persons in the family (on the top row); then circle whether the total family income is above or below the listed amount under that family size. Please include any related, dependent person over 65 or working dependent children over 18. *Total yearly income includes all sources of income for all family members residing in the household.
EXAMPLE: If your family consist of 2 people and your total yearly income is \$37,500; you would circle "2 PERSON AND Row (1) - "Equal to or Less Than \$37,650".

Number In Household	3 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON	6 PERSON	7 PERSON	8 PERSON
(1) Equal to or Less Than	\$33,150	\$37,650	\$42,600	\$47,300	\$51,100	\$54,900	\$58,700	\$62,450
(2) Equal to or Less Than	\$50,350	\$57,550	\$64,750	\$71,900	\$77,700	\$83,450	\$89,200	\$94,950
(3) Greater Than	\$50,350	\$57,550	\$64,750	\$71,900	\$77,700	\$83,450	\$89,200	\$94,950

SECTION II: MISCELLANEOUS STATISTICAL INFORMATION

Do you or anyone in the family: *Receive Child Support/Alimony? Yes No *Receive rental income from this property or other properties owned? Yes No If Yes, indicate how many _____
 Number of people in family over 62 years of age? _____ Are any family members physically disabled? Yes No If Yes, indicate how many _____
 Tenancy: Indicate if you are the Owner of this property or a Renter, Owner Renter How many families currently reside at this address? _____ (If more than one family, each family must complete a separate questionnaire).

RACIAL AND ETHNIC GROUPS - See Page 2 of this form for Racial and Ethnic Group Definitions.
 CSDBG Program requires both racial and ethnic information for all beneficiaries. From the list below, check (0) the racial and ethnic group that most closely reflects your ethnic origins.
 Please check the ethnic group to which you belong: Hispanic or Latino _____ Not Hispanic or Not Latino _____

- Please check the racial group to which you belong:
- White
 - Asian
 - Black/African American
 - American Indian/Alaska Native
 - American Indian/Alaska Native & White
 - American Indian/Alaska Native & Black/African American
 - Native Hawaiian/Other Pacific Islander
 - Other Multi Racial

Print Name and Title of Interviewer Completing This Form: _____
 Revised Section 8 Income Limits - Effective April 2018; Notice HUD PDR _____
 Interviewer's Signature: _____