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, please fill out ALL information in this packet.

Winslow THERAPEUTIC CENTER "Healing with Horses" SINCE 1974

2021 Update Form

PREMIER ACCREDITED CENTER PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

***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).**

Please complete pages 1-3 and submit to Winslow. If the participant has had health history and/or medication changes since last year, please fill out page 4 additionally.

Participant's Name: _____ Age: ____

Height: _____ Weight: _____ lbs. (Winslow has a weight limit of 225 lbs. for all mounted activities.)

Best number to contact for changes/updates: _____

Can we text you with changes/updates? Yes ☐ No ☐ If yes, cell phone number: _____

Email address: _____

Cancellation policy: Lesson cancellations made within 24 hours of the lesson time will incur at $25.00 charge. ___Initial

Bad Weather: Classes will only be cancelled in the event of dangerous or threating weather. To determine cancellations, call Winslow directly at 845-986-6686. ___ 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

Weight Limit: I understand that there is a weight limit of 225 lbs. for all mounted activities and acknowledge that if the participant surpasses this weight, they will be able to participate in unmounted activities as they work towards meeting the weight limit. ___Initial

Liability Release: _____ (PARTICIPANT'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: _____ Client/Parent/Guardian/Caregiver 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.

Participant's Name: _____ Date: _____

Client/Parent/Guardian/Caregiver Signature: _____

Client/Parent/Guardian/Caregiver Print Name: _____

Photo Release: 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: _____ Participant's name: _____

Mailing address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Cell phone: _____ Office phone: _____

Signature: _____ Relationship to participant: _____

I hereby confirm that there are *no* changes to the participant's health history and/or medications since last year.

Client/Parent/Guardian/Caregiver Signature: _____ Date: _____

Client/Parent/Guardian/Caregiver Print Name: _____

Participant's Name: _____

If participant has had changes in health history and/or medications since last year, please fill out page 4 of this document.

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

Facility Name: Facility _____ Address: _____

Program Name: _____ Number of Family Members Enrolled in Program: _____ Enrollment Date: _____

Date: _____ Participant's Place of Resident-Town/Village of: _____ 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 $37,850".

Number In Household)	1 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON	6 PERSON	7 PERSON	8 PERSON
(1) Equal to or Less Than	$33,150	$37,850	$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 ☐
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.
CDBG Program requires both racial and ethnic information for all beneficiaries. From the list below, check (1) the racial and ethnic group that most closely reflects your ethnic origin.
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
☐ Asian & White
☐ Other Multi Racial
☐ Black/African American
☐ Black/African American & White
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native
☐ American Indian/Alaska Native & White
☐ American Indian/Alaska Native & Black/African American

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

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Physician's Form

Please ONLY fill out if there have been changes to the participant's medical history in the last year.

Participant's Name: _____ DOB: _____

Height: _____ Weight: _____ lbs. (Winslow has a weight limit of 225 lbs. for all mounted activities.)

Address: _____ City: _____ State: _____ Zip: _____

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y ☐ N ☐ Date of last Seizure: _____

Shunt Present: Y ☐ N ☐ Date last revised: _____ Mobility: Walks Independently ☐ Needs Assistance ☐ Wheelchair ☐

Special precautions/needs: _____

Braces/Assistive Devices: _____

For those with Down syndrome: Result of Neurological exam of Atlantoaxial Instability: Present ☐ Absent ☐

Please indicate current or past special needs in the following system/areas, including surgeries:

Condition	Y	N	Additional Remarks Regarding Condition
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			