Participant's Application and Health History Update

To be completed at the start of each new year.
Please complete ALL information in this packet.

***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's Name: _____ DOB: _____ / _____ / _____ Age: _____
(mm/dd/yyyy)

Preferred Name: _____

Height: _____ (inches, feet) Weight: _____ lbs.

Preferred method(s) of contact: ☐ Call _____ ☐ Text _____

☐ Email _____

Legal Guardian Name: _____ Relation to Participant: _____

Home Phone: _____ Cell: _____

Address: _____

Legal Guardian Name: _____ Relation to Participant: _____

Home Phone: _____ Cell: _____

Address (if different from above): _____

Responsible for Billing:

First and Last Name: _____ Signature: _____

Home Phone: _____ Cell: _____ Email: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Photo Release:
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. ☐ Consent ☐ Do Not Consent
Participant's Name: _____

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Cancellation policy: Lesson cancellations made within 24 hours of the lesson time will incur a $25 charge. _____ Initial

Bad Weather: Classes will be cancelled in the event of dangerous/threatening 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 if the participant surpasses this weight, they will be able to participate in unmounted activities as they work towards meeting the weight limit. _____ Initial

Photo and Video Recording Policy: Winslow's confidentiality policy and photo release policy extend to participants, volunteers, animals, and staff. Prior to taking a photo or video recording your participant, you must ask the instructor to ensure that all individuals present have a photo release. There is also NO flash photography as this could startle the animals. _____ 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/Legal Guardian Signature: _____
(mm/dd/yyyy)

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/Legal Guardian Signature: _____
(mm/dd/yyyy)

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Primary Care Provider's Name: _____Facility: _____

Primary Care Provider's Phone: _____Preferred treatment facility: _____

Health Insurance Company: _____ Policy # _____ Group # _____

Has the participant had any changes in health history and/or medications in the past year? Check below.

- ☐ Yes, there have been changes – please have physician fill out page 4 of this document
- ☐ No, there have not been changes

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

Date: _____ / _____ / _____ Client/Parent/Legal Guardian Signature: _____
(mm/dd/yyyy)

Program Participation Income Survey

Orange County Community Development Office Requirement:
Winslow Therapeutic Riding Center is required by the Orange County Community Development Office (OCCD) to track the income range of all participants in order to continue receiving funding which subsidizes **ALL** lesson costs. **Using this form, in Section 1 please circle the applicable income limit listed under your household size.** Section II of the form is voluntary.
PLEASE NOTE: Winslow is committed to keeping the confidentiality of all client information and submits it anonymously. Please be assured that all data is held in strictest confidence. Thank you for helping Winslow qualify for funding that benefits all of our clients.

SECTION I

Residential Address: (optional)_____

Town/City: _____ State: _____ Zip: _____ County: _____

# of people in your household enrolled in Winslow's programs: _____ Year of Enrollment: _____

Using the chart below, please CIRCLE your income level based on the number of individuals in your household.

Number in household	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
(1) Equal to or less than	$33,150	$37,850	$42,600	$47,300	$51,100	$54,900	$58,700	$55,050
(2) Equal to or less than	$50,350	$57,550	$64,750	$71,900	$77,700	$83,450	$89,200	$94,050
(3) Greater than	$50,350	$57,550	$64,750	$71,900	$77,700	$83,450	$89,200	$94,050

SECTION II

How many families currently reside at the address listed above? _____
If more than one family, please have each family complete this questionnaire. Please copy the questionnaire or request a blank copy from Winslow.

Do you or anyone in the household receive rental income from the property listed above or any other owned? □ Yes □ No

Residency: □ Own □ Rent

Ethnic Group – please indicate the choice that pertains to the participant
□ Hispanic or Latino □ Non-Hispanic or Latino

Racial Group – please indicate the choice that pertains to the participant
□ White
□ Asia
□ Asian & White
□ 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

Do you or anyone in the household receive alimony/child support? □ Yes □ No

# of people in your family over the age of 62 years old: _____

Are any family members disabled? □ Yes □ No If yes, please indicate how many: _____

This form only needs to be completed if there have been changes to the participant's health history in the past year.

Participant's Medical Clearance and Physician Statement

Patient Name: _____ Patient DOB: _____ / _____ / _____

Height: ___ ft. ___ in. Weight: _____lbs.

Address: _____City: _____State: ____Zip: _____

Primary Diagnosis (write N/A if none): _____ Date of Onset: _____ / _____ / _____

Past/Prospective Surgeries (write N/A if none): _____

Medications (write N/A if none): _____

Seizure disorder? Yes No Type: _____ Controlled? Yes No Date of Last Seizure: ___ / ___ / _____

Does patient have a shunt present? Yes No Date of Last Revision: _____ / _____ / _____ N/A

Special Precautions/Needs: _____

Mobility (please circle one): Independent Ambulation Assisted Ambulation Wheelchair

Please indicate any braces of assistive devices (write N/A if none): _____

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:

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

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Accredited Center will weigh the medical information above against the existing precautions and contraindications.

Physician Name: _____ MD DO NP PA Other_____

Signature: _____ Date: _____ / _____ / _____

Facility Address: _____

Facility Phone: _____ License/UPIN number: _____