

Jacobs' Ladder Therapeutic Riding Center, Inc.
 5866 Bradford Rd. N.
 Hahira, GA 31632
 229.794.1188



www.jacobsladderriding.com

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Mailing Address: _____

Primary Contact Phone: _____ Alternative Phone: _____

Email Address: _____

Employer/School: _____

Parent/Legal Guardian/Caregiver: _____

In the event of an emergency, contact:

Parent/Legal Guardian: _____ Phone: _____

Name: _____ Relation _____ Phone: _____

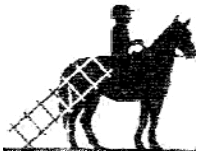
Name: _____ Relation _____ Phone: _____

HEALTH HISTORY

Diagnosis: _____ Date of onset: _____

Please indicate current or past problems in the following areas:

| | Yes | No | Comments |
|-------------------------|-----|----|----------|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional/Mental Health | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |



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MEDICATIONS (Include prescription and over-the-counter medications, name, dose and frequency)

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHOSOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc...)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Signature: _____

Date: _____

PHOTO RELEASE

I **DO** **DO NOT** consent to and authorize the use and reproduction by Jacobs' Ladder Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian
 Signed in the presence of operating center staff