

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



[www.jacobsladderriding.com](http://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: \_\_\_\_\_

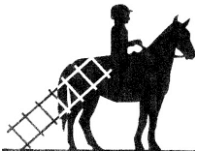
Name: \_\_\_\_\_ Relation \_\_\_\_\_ Phone: \_\_\_\_\_

## 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)

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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)

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

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

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**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