Participant Application/Registration

Participant Name:_____ DOB:_____

Diagnosis: _____ Onset: _____

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

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____(h) _____(w) _____(cell)

Employer/School: _____

Parent/Legal Guardian/Caretaker: _____

Address: _____

Telephone: _____(h) _____(w) _____(cell)

Email: _____ Referral Source: _____

Telephone: _____ How did you hear about **EQUI-KIDS**? _____

Participant Health History

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Fear/aversion to animals			

Medications (include prescription, over-the-counter; name, dose and frequency, side effects encountered):

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

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

Psycho/Social Function (work/school including grade completed, leisure interests, relationship-family structure, support system, companion animals, fears/concerns, etc):

Goals (Why are you applying to participate? What would you like to accomplish?):

Dated: _____ _____

Participant/Parent/Guardian/Caretaker

Date:_____

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

NEUROLOGIC

Hydrocephalus/shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

OTHER

Age - Under 4 Years
Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. Should you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,
Kathy Chitwood, RN,BC
Program Director
EQUI-KIDS Therapeutic Riding Program
2626 Heritage Park Drive
Virginia Beach VA 23456
757-721-7350 (phone)
757-721-7354 (fax)