COFFEE CREEK RIDING CENTER

"Therapeutic Horsemanship"
17 E. Coffee Creek Rd., Edmond, OK 73034
(405) 340-8377

Rider's Application, Release & Health History

GENERAL INFORMATION Note: 165 lb. weight limit!

Participant's Name_____DOB_____Age_____
Height_____ Weight_____ Male_____ Female_____
Parent/Legal Guardian_____
Address_____City_____State____Zip_____
County_____School_____
Phone_____ Alternative #_____ E-mail_____
How did you hear about the program?_____

I am applying for the above named student to participate in the therapeutic riding program. The ability of the center to serve a student is based on the availability of appropriate volunteers, horses, and instructors. In addition, physical or behavioral circumstances of the student may affect their ability to participate safely and the centers ability to provide services I understand that the program may rotate the students served in each class term/session to allow maximum participation. Schedules are changed at the end of each class term/session. When a class space is not available, the student may be placed on the alternate list (riding on call in classes where students are absent).

Signature_____ Date_____
(Participant, Parent or Guardian)

PHOTO/VIDEO RELEASE

I [ ] DO [ ] DO NOT
Consent to and authorize the use and reproduction by **Coffee Creek Riding Center** of any and all photographs and any other audio/visual material taken of me, or my child, for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Participant's Name_____

Signature_____ Date_____
(Participant, Parent or Guardian)

HEALTH HISTORY

Diagnosis_____

Please indicate current or past problems 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			

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

_____

_____

_____

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

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

_____

_____

PSYCHO/SOCIAL 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_____

(Participant, Parent or Guardian)