A HORSE CONNECTION

REGISTRATION PACKET

Date: _____

Client: _____ Date of Birth: _____ Age: _____

Address: _____

Parents or Guardian: _____

Address: _____

Daytime Phone (HOME/WORK): _____ Evening Phone (HOME/WORK): _____

Mobile or Pager Number: _____

Email Address: _____

School or Facility presently attending: _____

In case of emergency contact: _____ Phone: _____

Or Contact: _____ Phone: _____

Have you or your child ever been around or on a horse or pony? Please describe when, where, response.

Please provide any scheduling information you have that will help us meet your needs, ie: Preferred Days/Times/Hours of school/Hours of work:

Please use the space to provide any additional information or experience you would like to provide that will help the equine assisted therapy team best serve you/your child's needs:

If services are for your child, does your child have siblings? If so, have they ever been around or on a horse/pony? Please describe.

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

Describe participant's abilities/difficulties in the following areas (include assistance required or equipment needed).

PHYSICAL FUNCTION (ie Mobility skills such as transfers, walking, wheelchair use, driving):

PSYCHOSOCIAL FUNCTION (ie Work/school, leisure interests, support systems, family relationships, companion animals, fears/concerns/aspirations, etc):

COMMUNICATION FUNCTION (ie verbal, non-verbal, gestural, picture/symbols - Methods used for current communication, etc.):

GOALS (ie Why did you apply for participation? What would you like to accomplish?):

Thank you for taking the time to fill out this information that will be helpful in best serving your needs!