WHISPERING HORSE FARM
253 Hampden Road
East Longmeadow, MA 01028
413-525-2174

Participant's Application and Health History

to be completed by the participant, or parent/legal guardian

GENERAL INFORMATION

Participant: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ M F

Address: _____

Phone: (___)_____ Alternative: _____

Employer/School: _____

Address: _____

Phone: (___)_____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Contact numbers: _____

How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y/N	Comments
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional		
Behavioral		
Pain		
Bone/Joint		
Muscular		
Thinking/cognition		
Allergies		

What medications are you currently taking, including over the counter medications? _____

_____

_____

WHISPERING HORSE THERAPUTIC RIDING CENTER
25 Hampden Road
East Longmeadow, MA 01028
413-525-2174

Consent for Treatment and Release of Liability

"No child can be accepted for hippotherapy or theraputic riding until all forms have been completed by the parent/guardian. If the patient is of legal age and mentally competent, he/she may complete the forms without parent's or guardian's signature."

"Although every effort will be made to avoid accident or injury NO LIABILITY can be accepted by any of the organizations concerned including Whispering Horse Theraputic Riding Center, its officers, trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the hippotherapy or theraputic riding sessions are Conducted."

I request and consent to treatment that may include hippotherapy or Theraputic riding and I have discussed this with my (my child's) doctor. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including Whispering Horse Theraputic Riding Center.

Dated signatures of parent/guardian or patient of legal age must be included.

Clients Name: _____

Signature: _____

Date: _____

WHISPERING HORSE Farm
253 Hampden Road
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Participant's Authorization for Emergency Medical Treatment

Please Print Clearly

Participant's name: _____ Date of Birth: _____ Phone: _____
Address: _____
Physician's Name: _____ Medical Facility: _____
Health Insurance Co: _____ Policy #: _____
Allergies to medications? _____
Current medications: _____

In the event of an emergency, contact:

Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above can not be reached, I authorize *Therapist Name* to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

Date: _____ Consent signature: _____
Client, Parent or Legal Guardian
Signed in the presence of Operating Center staff

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the even emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____

Date: _____ Non-consent Signature: _____
Client, Parent or Legal Guardian
Signed in the presence of Operating Center staff

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM