Calvin Center
Therapeutic Riding Program

Calvin Center Equestrian Program Rider Application

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business: _____ Cell: _____

Email Address: _____

Parent/Guardian: _____ Parent Phone: _____

Emergency Contact: _____ Phone: _____

School: _____

School Address: _____

Best way to contact you: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ E-mail

Who should we contact regarding application, scheduling, cancellations, billings, etc?:

Contact name: _____

Contact phone: _____ Contact e-mail: _____

Participant's school program: _____ Phone: _____

Participant's special education case manager: _____ Phone: _____

Physician's name: _____ Phone: _____

Specialist physician's name: _____ Phone: _____

Specialist physician's name: _____ Phone: _____

Disability (primary): _____

(secondary): _____

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Weight: _____ Height: _____ Verbal: ☐ Yes ☐ No

Primary mode of communication: _____

Describe participant's abilities/difficulties with function (i.e. mobility skills such as transfers, walking, wheelchair use.) Include assistance required or equipment needed:

Describe participant's social abilities/difficulties:

Has participant ridden before? If so, what type of riding? _____

What interests, activities and hobbies does the applicant enjoy at home and/or school?

Calvin Center Therapeutic Riding Program strives to meet a rider's individual goals. These may include recreation, education, etc. Please share goals for participating in this program:

Please describe any additional fears, issues or characteristics of the applicant that our staff and volunteers need to know in order to best serve the applicant:

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Participant's Authorization for Emergency Medical Treatment Form

Please print. Use blue or black ink.

If participant is under the age of 18 years of age or dependent, form must be signed by parent/legal guardian where indicated.

Participant name: _____ Date: _____

Address: _____

Parent/legal guardian name if under 18 or dependent: _____

Home phone: _____ Alternate phone: _____

Date of birth: _____

List three other contacts in case of emergency:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Physician's name: _____

Preferred medical facility: _____

Health insurance company: _____ Policy #: _____

Name of primary insured on policy: _____

Participant's social security number: _____

Social security number of primary insured: _____

Allergies to medications (describe reaction):

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Other Allergies (environmental, food, etc.):

Date of last tetanus shot: _____ Tuberculosis test: + ☐ or – ☐ Date: _____

Recent hospitalizations, surgeries or other health concerns:

Please list current medications on the back of this sheet.

Consent for emergency medical treatment:

In the event emergency medical aid/treatment is required due to illness or injury during the process of volunteering, or while being on the property of the agency, I authorize Calvin Center/Presbytery of Greater Atlanta to secure and retain medical treatment and transport if needed and to release participant records upon request to the authorized individual or agency involved in the emergency medical treatment. 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(s) above is unable to be reached.

Participant consent

Signature: _____ Date: _____

Printed name of participant: _____

Participant's parent or legal guardian signature if under 18 or dependent:

_____ Date: _____

Printed name of parent or legal guardian if under 18 or dependent: _____

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PARTICIPANT'S HEALTH HISTORY:

Please fill out completely. Attach additional sheet of paper if necessary. Please indicate current or past problems in the following areas:

Area	Y	N	Comments
Vision	◯	◯	
Hearing	◯	◯	
Sensation	◯	◯	
Communication	◯	◯	
Heart	◯	◯	
Respiratory	◯	◯	
Digestion	◯	◯	
Elimination	◯	◯	
Circulation	◯	◯	
Emotional	◯	◯	
Behavioral	◯	◯	
Psychological	◯	◯	
Thinking/Cognition	◯	◯	
Pain	◯	◯	
Bone/Joint	◯	◯	
Muscular	◯	◯	
Allergies	◯	◯	

Please list any current medications participant is taking, dosage, times taken and reason for taking:

I certify that I have supplied this health history information and that to the best of my knowledge, it is up to date, legal and accurate.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____