USU EQUINE EXPERIENCE

Equine-Assisted Activities and Therapy

Participant's Application & Health History

Empowering Individuals Through Education and Service

702-238-5870
michelle.weed@usu.edu
Visit us on our Facebook Page: USU Equine Experience
3580 South Hwy 89/91
Wellsville, UT 84339

Client Contact Information

Legal Full Name: _____

Date: ___/___/___ Age: ____ Date of Birth: ___/____/____

Male:____ Female:____ Height: ___ft ____in Weight: _____

Address: _____

City:_____ State/Country:_____ Zip Code:_____

Home Phone: _____

Cell Phone: _____ Text: Y N

Email: _____

Primary Language spoken/understood: _____

Parent/Legal Guardian/Caregiver Information

Name: _____ Relation:_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Diagnosis

Primary: _____

_____

Secondary: _____

_____

Details: _____

_____

_____

Date of Onset: _____

Allergies

List all know Allergies, Reactions, and Medications

___ No Concerns (if no concerns continue to Medical Information)

_____

_____

_____

_____

_____

Military Service

_____ None _____ Current _____ Former

Branch: _____

Dates Served: _____

Wounded Warrior Project Alumni: _____ Yes _____ No

Referral

Referral Source: _____

How did you hear about the program? _____

_____

What programs are you interested in:

❑ Therapeutic Riding
❑ Equine Assisted Learning
❑ Hippotherapy
❑ Equine Assisted Psychotherapy
❑ Not Sure

Behavior Therapy

Please check any of the following therapies that you or your child are currently participating in.

❑ ABA-Applied Behavioral Analysis
❑ DIR-Floortime
❑ Miller Method
❑ RDI-Relationship Development Intervention
❑ TEACCH-Treatment and Education of Autistic & Communication Handicapped Children
❑ SCERTS-Social Communication Emotional Regulation Transactional Support
❑ Son-Rise Program

Media/Photo/Audio/Video Waiver

_____ I hereby authorize and give my full consent to Utah State University to publish any/all photographs, audio and or video in which I appear while attending USU Equine Experience activities and events.

_____ I do not give my consent to USU Equine Experience to copyright, publish, transfer, or otherwise use any photographs, videotapes, or film.

_____ I understand this is a public facility, so this can only be enforced for USU employees and volunteers.

_____ _____

Signature of Participant (or Guardian if under 18) *Print Name of Parent/Guardian – (If under 18)*

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Client Name: _____

To be filled out by participant, or parent if under 18

Please Indicate current or past difficulties in the following areas:

	Y	N	Comments		Y	N	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary/Skin				Emotional/Psychological			
Immunity				Pain			
Pulmonary				Other			
Neurologic							
Medications:							

Abilities/Difficulties

Describe your abilities/difficulties in the following areas (include assistance/equipment needed):
Function (Ex. Mobility skills-transfers, walking, wheelchair, etc.)

_____

_____

_____

Social (Work/School, companion animals, fears/concerns, etc.)

_____

_____

Goals

What would you like to learn/accomplish in this program?

_____

_____

Emergency Information

In the event of emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____