Destiny 's Ride
Therapeutic Equestrian Program
Mailing Address 406 Old Post Rd ~ Stop 24
Ghent, NY 12075
(518)822-0562

Participant's Application, Photo Release, and Health History

GENERAL INFORMATION:

Participant's Name: _____

DOB: _____ Age:_____ Height:_____ Weight:_____ Gender: M F

Address Street: _____ City:_____ State:_____

Zip:_____

Home #:_____ Cell # /Work#:_____ E-mail:_____

Employer/School: _____ Phone: _____

Address: _____

Parent/Legal Guardian/Caregiver: _____

Address (if different from above):_____

Phone #:_____ Alternative #:_____

If you are a new applicant:

How did you hear about our program? _____

If referred, please list source and date: _____

If you have any previous riding/horse experience, please describe: _____

_____

If you currently ride at Destiny's Ride Inc. please list start date: _____

PHOTO RELEASE:

I DO / DO NOT **(please circle one)** consent to and authorize the use and reproduction by Destiny's Ride Therapeutic Equestrian program, Inc. of any and all photographs and any other audio/visual materials taken of me/my son/daughter/ward for promotional materials, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Participant (Parent or Legal Guardian)

Lessons at Destiny's Ride are a team effort. Your instructor wants and appreciates your input throughout the riding session. Please feel free to ask questions, make suggestions, and give feedback. Discussions of any length can be done on the phone or via e-mail. joconnell@destinysride.org / (518)822-0562

RIDING GOALS: (What you would like to accomplish during your time with us.)
Short Term (During the next 6–12 months): _____
_____
_____
Long Term (During the next 2-3 years): _____
_____
_____

OTHER GOALS: (This could include social, recreational, professional/career, etc.)
_____
_____
_____

AREAS OF FOCUS/STRENGTHS/WEAKNESSES
Riding a horse involves many aspects of the whole person; the physical, cognitive, and emotional. Participating in riding lessons adds even more dimensions to the scenario, such as our learning styles, spatial awareness, social interactions, etc. Please use this section to discuss information that you believe might be helpful or issues that you would like addressed, so that the instructor can created a beneficial, supportive lesson environment for you/your child. A good place to start might be the teaching environment, aids, and tools that best supports your learning style and needs._____
_____
_____
_____
_____

MISC. HEALTH ISSUES
Please include any health issues (i.e. allergies, asthma, reactions to medications, dizziness, etc.) that you feel staff should be aware of. _____
_____
_____
_____

PREFERENCES
Although the needs and requirements of all our riders is the priority, every effort is made to accommodate the preferences of our riders. Toward that goal, please feel free to share with us your "favorites" in horses and tack. It would be beneficial if you would explain why you prefer a certain horse or piece of equipment so that, if we can not exactly meet your wishes, we can come close. _____
_____
_____
_____

CONCERNS
This could include any past riding experiences that caused a loss of confidence, any conditions or circumstances that you feel could interfere with your ability to ride safely or to your full potential, any fears, etc _____
_____

HEALTH HISTORY

Diagnosis_____ Date of Onset _____

Please indicate current or past special needs 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 and over-the-counter: name, dose, and frequency):

_____

_____

Describe your abilities/difficulties; (include assistance required or adaptive equipment needed):

PHYSICAL FUNCTION (i.e. Mobility skills such as transfer, walking, wheelchair use):_____

_____

_____

COGNITIVE/LEARNING SKILLS (i.e. Learning Disabilities, communication aids or tools)

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (i.e. Work/school, behavior/safety issues, relationship-family structure, support systems, fears/concerns etc.:_____

_____

_____

Signature: _____ Date: _____

Participant (parent or guardian)