FAIR HILL THERAPEUTIC RIDING CENTER

PO Box 396, Waymart, PA 18472
Phone: 570- 390- 8695
email: fhtrc2019@gmail.com

Participant Initial Application

This form will provide the information we need to contact you when a lesson slot is available. All participants must have a Medical Form filled out and signed by their doctor as well as other necessary forms prior to starting. In order to set appropriate goals and assure safety an initial assessment of skills is also required. Should you have questions, or would like additional information feel free to call or email us.

Participant Name_____Age_____DOB_____Date_____

Name of parent or guardian if under 18_____

Contact Information

Street_____City_____State_____zip_____

☐ Home Phone ☐ Cell ☐ text ☐ email

_____ _____ _____

Please check box indicating preferred contact method

MEDICAL INFORMATION

Gender _____Age _____Height _____Weight _____

Primary Diagnosis_____ **Secondary Diagnosis**_____

Ambulation_____ **Communication** Verbal / Assisting Device / Sign Language
Non-verbal/Limited /Verbal Expression

Balance (majority of the time) Well Balanced / Impaired Balance

Seizure Information (circle one) does not apply / well controlled with medication / not controlled with medication

Behavior Information (circle one) compliant / oppositional / easily frustrated or upset / fearful / other_____

What is the greatest challenge / goal that you hope to address with therapeutic riding?

Please tell us about yourself. Include your strengths and interests. Please use the back of the form if needed.
You may consider the following areas:

a. Learning/knowledge
b. Emotional and/or Behavior
c. Community Participation (**safety, group interaction**)
d. Independent Living **(responsibility, habits**)
e. Job Training (**relating to self-sufficiency or employment**)
g. Recreational Opportunities

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Please mail or email the completed form. Address and email are found at the top of this form.