

PO Box 396, Waymart, PA 18472
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Participant Initial Application - Please fill out this form to initiate the enrollment process. Once this form is reviewed, we will contact you with the next steps. Please note that we are currently operating with a waiting list.

Participant Information

Name: _____ Age: _____ DOB: _____ Date: _____
Parent/Guardian (if under 18): _____
Street: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Cell: _____ Text: yes/no
Email: _____ Preferred method of contact _____

Program Selection (Check one) ☐ Equine Assisted Learning ☐ Therapeutic Riding ☐ Undecided

Medical Information

Gender: _____ Height: _____ Weight: _____ (Needed for Therapeutic Riding Participants Only)
Primary Diagnosis: _____ Secondary Diagnosis: _____
Ambulation: _____

Communication: ☐ Verbal ☐ Assisting Device ☐ Sign Language ☐ Non-verbal/Limited Expression

Balance: ☐ Well Balanced ☐ Impaired Balance

Seizures: ☐ Does not apply ☐ Well controlled with medication ☐ Not controlled

Behavior: ☐ Compliant ☐ Oppositional ☐ Easily frustrated ☐ Fearful ☐ Other: _____

Goals & Interests

What is the greatest challenge/goal you hope to address with this program? _____

Tell us about yourself, including strengths and interests. _____

Please send in the mail or email the completed form to the address or email at the top of this form.