KaleidoScope Therapeutic Riding Program
21 Branin Road
Medford, NJ 08055
609-923-7847

Participant's Application & Health History

To be completed annually

Participant: _____ Date of Birth: _____Age_____
Address_____City_____State____Zip_____
Phone:_____Email:_____Alternative #:_____
Employer/School:_____
Address:_____
Phone:_____ Name of Parent/Guardian: _____Caregivers:_____
Address (if different from above):_____City_____State____Zip_____
Phone:_____ Referral Source:_____
How did you hear about the program?_____
Diagnosis: _____ Date of Onset: _____
*** For Persons with Down Syndrome:*
- ☐ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date _____
- ☐ Negative for clinical symptoms of Atlantoaxial Instability.

Tetanus Shot: ☐ Yes ☐ No Date _____ Height _____ Weight _____ Gender: M F
Seizure Type _____Controlled _____ Date of last Seizure _____
Medications _____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation ☐ Yes ☐ No Crutches ☐ Yes ☐ No Braces ☐ Yes ☐ No
Wheelchair ☐Yes ☐No Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) _____
Physician Signature_____
Address_____City_____State____Zip_____
Phone _(_____)_____ Date _____

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