



HorseFriends, Inc.
 PO Box 10211
 Greensboro, NC 27404

HorseFriends Participant's Application and Health History
(To be completed by participant, parent or legal guardian)

GENERAL INFORMATION

Participant: _____ Age: _____
 DOB: _____ Height: _____ Weight: _____ Gender: M F
 Address: _____
 Phone: _____ Alternative #: _____
 E-mail: _____
 Employer/School: _____
 Address: _____
 Phone: _____
 Parent/Legal Guardian: _____
 Address (if different from above): _____
 Phone: _____ Alternative #: _____
 How did you hear about the program? _____

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 prescriptions, over-the-counter, name, dose and frequency)

Additional information that may be helpful: _____

SIBLINGS – *We encourage sibling participation. Please list children you would like to participate.*

Sibling Participant: _____ Age: _____

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

Sibling Participant: _____ Age: _____

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Sibling Participant: _____ Age: _____

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

Additional information on siblings that may be helpful: _____

Please Print Your Name: _____

Signature of Participant or Parent/Legal Guardian

Date