Loudoun Therapeutic Riding, Inc.
At the Morven Park Equestrian Center
41793 Tutt Lane
Leesburg, Virginia 20176
703-771-2689 Fax: 703-779-1368
www.ltrf.org

# Participant's Application and Health History

**General Information**:

**Participant**:_____

**DOB**: _____ **Age**: _____ **Height**: _____ **Weight**: _____ **M**__ **F**__

**Address**: _____ **ZIP**:_____

**Phone**: _____**Email**:_____ **Cellular**: _____

**Employer/School**: _____**Phone**:_____

**Address**:_____

**Parent/Legal Guardian/Caregivers**: _____

**Address**: (**if different from above**)_____

**Phone**: _____

**Referral Source**: _____ **How did you hear about our center?** _____

**Health History**: ***Please indicate current or past special needs in the following areas:***

**Diagnosis**: _____ **Date of onset**:_____

| | 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, frequency)*_____

_____

_____

_____

*Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):*

**PHYSICAL FUNCTION** *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

_____

_____

**PSYCHO/SOCIAL FUNCTION** *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fear/concerns, etc.):*_____

_____

_____

_____

**GOALS** *(i.e. Why are you applying for participation? What would you like to accomplish?)*

_____

_____

_____

***I have read and agree to all Policies, Procedures, Rules, and Guidelines established for participation in LTR programs or activities.*

***Signature:*** _____ ***Date:***_____

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***PHOTO RELEASE*** *:* *I ____ Do* *I ____ Do not*

*Consent to and authorize the use and reproduction by Loudoun Therapeutic Riding Foundation, Inc. of any and all photographs and any other audio/visual materials taken of me and/or my child for promotional material, social media, educational activities, exhibitions or for any other use for the benefit of the program.*

***Signature:*** _____ ***Date:***_____

*(Client, Parent or Legal Guardian)*