YEAR: ____________

FREDERICK COUNTY 4-H THERAPEUTIC RIDING PROGRAM
WAITING LIST APPLICATION

*{Parents/Guardians please fill out this form **completely** to be placed on our Waiting List. You will be asked to complete other forms – Physicians Referral, Liability Release, Emergency Medical Release, Therapist and Teacher Assessment Forms – during the Registration Period prior to possible enrollment}*

CLIENT NAME: ____

Date of Birth: ____________________ Height ______________ Weight __________________

Handicapping Condition (Diagnosis): ____

____

If SPINA BIFIDA or other Spinal Cord involvement - what level vertebrae? __________________

Current Medical History ____

____

Surgical Procedures & Dates ____

____

Current Medication ____

____

Does the patient use: Braces _____ Cane _____ Crutches _____ Walker _____ Wheelchair _____ Hearing Aid ______

Other (specify) ____

Does the patient have any other problems which may affect his/her ability to ride? Check and describe on the back of the page.

_____Auditory
_____Speech
_____Vision
_____Circulation
_____Balance and Coordination
_____Acute stages of arthritis
_____Open pressure sores or open wounds
_____Incontinence
_____Pain
_____Hemophilia
_____Spasticity and/or rigidity
_____Pathological fractures
_____Serious heart condition
______Seizures (Controlled for 1 year?) Explain
_____Ataxia or apraxia
_____Allergies
_____Osteoporosis
_____Orthopedic limitations
_____Unstable spine

PARENT NAME ____________________________

ADDRESS ____________________________

____

HOME PHONE ____________________________

CELL PHONE ____________________________

EMAIL ADDRESS ____________________________

EMPLOYMENT ____________________________

PARENT NAME ____________________________

ADDRESS ____________________________

____

HOME PHONE ____________________________

CELL PHONE ____________________________

EMAIL ADDRESS ____________________________

EMPLOYMENT ____________________________

SIGNATURE & DATE

____

SIGNATURE & DATE

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