



Safe Haven Farms Equine Assisted Riding
To Be Completed by Participant or Caregiver
Participant's Application & Health History

Participant Name: _____ DOB: _____ Current Age: _____

Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Participants Lives with: _____

Employer/School: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone : _____ Email : _____ Email : _____

Referral Source: _____

If student works with a therapist or teacher, may we contact them? ☐ Yes ☐ No ☐ Let's Discuss

Therapist/Teacher Name: _____ Email/Phone: _____

HEALTH HISTORY

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis: _____ Other: _____

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 THAT COULD IMPEDE PARTICIPANT PHYSICALLY OR COGNITIVLY: List Medication, Use, Reaction

This information helps us develop goals, curriculum, and support the student.

PLEASE DESCRIBE THE FOLLOWING:

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding) _____

PSYCHO/SOCIAL FUNCTION (e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

BEHAVIORAL CHALLENGES (triggers, aggression, self-regulation, social skills)

GOALS (why are you applying for participation? What would you like to accomplish at this program)

Person Completing Form: _____

Relationship to Applicant: _____

STAFF NOTES

Are there any contraindications to participating in EAS? ☐ YES ☐ NO ☐ Possibly, needs further eval

Are there any contraindications for horseback riding? ☐ YES ☐ NO ☐ Possibly, needs further eval
