T.H.E. CENTER INC.

Therapy for **H**andicapable **E**questrians
P.O. Box 5337, Hemet, CA 92544
Phone (951)-658-7790 Fax (951)-765-6001
www.t-h-e-center.org   *info@t-h-e-center.org*

Administrative Use Only

☐ NEW   Start date:________
☐ RETURNING
Orig Date: _________
Return Date:_______
Type: T S GP
☐ Physician: Date: ________
☐ No Change
☐ CDBG
☐ Emergency Authorization
Treat
No Treat ____________
☐ Liability Release
☐ Photo: Yes NO
INITIAL: DATE:

STUDENT Application and Health History

GENERAL INFORMATION

Participant's Last Name: ________________________________ First Name______________________________

Address: ______________________________________ City: _________________________ Zip: ____________

Phones: Home ______________________ Cell:______________________ Work: ________________________

E-mail Address:____

DOB: _________________ Age: ________ Height: ____________ Weight: ___________ Gender: M F

School: _______________________________________ Phone: _______________________________

Teacher: ____________________________________ Phone: ____________________

Parent/Legal Guardian Name: ____

Address: (if different than above) ____

City: ______________________________ Zip: ___________ Phone: ____________________ Cell: ___________

Parent Employer: ____ Phone: ______________________

How did you come to know about our program: ____

Did you attend T.H.E. Center in 2005-2006: Yes________ No______

HEALTH HISTORY

Diagnosis: ____ Date of Onset: ________________

Please indicate current or past needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Muscular			
Thinking/Cognition			
Bone/Joint			
Allergies			

STUDENT Application and Health History – Page 2

MEDICATIONS

Name	Prescription	Over the Counter	Dose	Frequency

PHYSICAL FUNCTION

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed) For example: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding.

____

____

____

____

PSYCHO/SOCIAL FUNCTION

What grade completed/work force, leisure interests, family structure, relationships, support systems, pets, fears, concerns, etc.____

____

____

GOALS: Why do you want to be a student at T.H.E.? What would you like to accomplish?

____

____

PHOTO RELEASE

☐ **I Do** ☐ **I Do Not**

consent to and authorize the use and reproduction by **T.H.E. CENTER, INC.** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the program.

SIGNATURE: Student (if over 18):____

SIGNATURE: Parent or Legal Guardian: ______________________________________

Date: __________________________

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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☐ Student
☐ Volunteer
☐ Staff
☐ Board Member

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Name: ______________________________ Date of Birth: ____________________

Address: ____________________________ City: ________________ Zip: __________

Phone: (H) ________________ (C) ____________________ (W) ______________________

Physician's Name: ______________________________ Medical Facility: _______________

Health Insurance Co: ____________________________ Policy #: ____________________

Allergies to Medications: ____

In the event of an emergency contact:

Name: ____________________ Relationship: ______________ Phone: ________________

Name: ____________________ Relationship: ______________ Phone: ________________

Name: ____________________ Relationship: ______________ Phone: ________________

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize T.H.E. Center, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

☐ **Consent**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature:

____

Date: ____________________

☐ **Non- Consent**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of T.H.E. Center, Inc.
In the event emergency treatment/aid is required, I wish the following procedures to take place: Please write detail on back & be specific.

NON-CONSENT Signature:

____

Date: ______________________

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LIABILITY RELEASE

As a volunteer/staff/student/board at T.H.E. Center, Inc. I acknowledge the risks and the potential risks of a horseback riding program. However, I feel the possible benefits to myself and the participants I work with are greater than the risk assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against T.H.E. Center, Inc. its' Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in T.H.E. Center, Inc. program.

If volunteer is under 18 years of age, Parent/Guardian must sign.

Name (Please Print) ______________________________________

Signature: ____

Signature: ____
Parent/Guardian – if minor or legal guardian)

Date: ______________________

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