



T.H.E. CENTER INC.

Therapy for Handicapable Equestrians

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: _____





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- 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: _____

