<table>
<tr><td> </td><td>Good Hope Equestrian Training Center, Inc.
22155 SW 147 Avenue
Miami, FL 33170
(305) 258-2838</td></tr>
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Participant Application & Medical/Health History

***Note: Please include all reports and documents available in this area along with the application. Pages 2-4 need to be completed and signed by the participant's physician.**

Participant's Name: ____

Primary Physician's Name, address, and telephone number:

____

____

____

Childhood diseases (Note age) Mumps: ________ Measles: __________
Chicken Pox: __________ Diphtheria: _________ German measles: ________
Whooping Cough: __________

Operation(s) (Note age):

____

____

Accident(s) (Note age):

____

____

Hospitalization(s) (Note age):

____

____

If there is a history of a convulsive, seizures, or epileptic disorder, please answer the following questions:
At what age did the applicant experience onset of disorder? _________ Describe the type of convulsions/seizures the applicant had?

____

____

What was the date of the last seizure or convulsion? ___________________________

<u>Immunizations</u> <u>Dates</u>
D.P.T. ____

D.P.T. Booster ____
Tetanus Booster ____
Polio (4x) ____
Measles ____
Rubella ____
Mumps ____
T.B. Skin Test ____
M.M.R. (Mumps/Measles/Rubella Injection) _________________________
Please list any other
immunizations____
____
***Note: Please attach all immunization documentation.**

Examination
***Note: This portion of the application needs to be evaluated by your primary physician. Please attach copies of reports from physician.**

Hearing Test ____
Eye Exam ____
Dental Exam ____
Physical Exam ____
Orthopedic Exam ____

(Please attach copies of reports of previous consults/tests/etc. obtained from doctor)
Neurological Evaluation ____
Psychological Evaluation____
Electroencephalalogram (EEG) ____
Pneumoencephalogram ____
Electrocardiogram ____
X-Rays ____
Blood Chemistries ____

Precautions & Contraindications in Therapeutic Horseback riding

***Note: Physician must complete this portion of the application.**

Please check the following conditions that apply to your patient.
Orthopedic _________
Spinal Fusion ___________
Spinal Inability/Abnormalities __________
Atlantoaxial Instability _________
Scoliosis _________
Kyphosis __________
Lordosis __________
Hip Subluxation and Dislocation __________
Osteoporosis __________
Pathologic Fractures __________

Coxa Arthrosis __________
Heterotrophic Ossification __________
Osteogenesis Imperfecta __________
Cranial Deficits __________
Spinal Orthoses __________
Internal Spinal Stabilization Devices __________

Neurological
Hydrocephalus/Shunt __________
Spina Bifida __________
Tethered Cord __________
Chiari II Malformation __________
Hydromyelia __________
Seizure Disorders __________

Medical/Surgical
Allergies _________
Cancer __________
Diabetes __________
Peripheral Vascular disease __________
Varicose Veins __________
Hemophilia __________
Hypertension __________
Serious Heart Condition __________
Stroke (Cerebrovascular Accident) __________

Other Disorders & Conditions
Multiple Sclerosis __________
Arthritis __________
Aggressive Behavior __________
Indwelling Catheters __________
Skin Breakdown __________

If your patient has any of the following condition, please describe them in detail. In addition, do you believe your patient's condition could worsen if he/she participates in therapeutic horseback riding? Yes __________ No __________

____
____
____
____
____
____

Please list all of the medical problems, which are now under treatment. Include present medications of all kinds, which the applicant receives, including dosage and when and how the medicine is administered

____
____
____
____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Good Hope Equestrian Training Center will weigh the medical information above against the existing precautions and contraindications. I concur with the participant's anilities/limitations by a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/title: ________________________________ MD DO NP PA __________ other
Physician's signature: ____
Date: _____________
Address: ____
Phone: ____

Participant Educational Background

Please list in order of attendance, all school enrollments

Name	Address	Grades/Years of attendance	Contact at school

Participant Vocational/Employment

Please list current first, and then previous participation in adult activity programs, developmental training centers, supported employment and/or competitive employment.

Name	Address	Date of attendance	Contact at program	Reason for leaving

Recreational/Leisure Interests

Please list any activities in which your son or daughter enjoys?

____

____

____

Personal References

Please list three personal friends/associates of the family.

Name	How long you have known each other?	Type of Relationship

Right to Revoke Services

Good Hope reserves the exclusive right in its sole discretion to deny a participant's application for any or no reason, or to remove an accepted participant from the program in Good Hope's sole discretion.

Authorization for release of Information

Applicant authorizes Good Hope to investigate their medical, educational and adult programming records for evaluational purposes, and hereby authorizes any personnel of any records to release this information to Good Hope Equestrian Training Center.

______________________________ ______________

Applicant's signature **Date**

____

Signature of legal guardian