



**Good Hope Equestrian Training Center, Inc.**  
 22155 SW 147 Avenue  
 Miami, FL 33170  
 (305) 258-2838

**Participant Application & Medical/Health History**

\*Note: Please include all reports and documents available in this area along with the application.

**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?** \_\_\_\_\_

<b><u>Immunizations</u></b>	<b><u>Dates</u></b>
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**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)** \_\_\_\_\_

**Examination**

\*Note: If applicable, please list most recent date assessment tests were given:

**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** \_\_\_\_\_

**Electroencephalogram (EEG)** \_\_\_\_\_

**Pneumoencephalogram** \_\_\_\_\_

**Electrocardiogram** \_\_\_\_\_

**X-Rays** \_\_\_\_\_

**Blood Chemistries** \_\_\_\_\_

**Precautions & Contraindications in Therapeutic Horseback riding**

\*Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**Orthopedic Conditions**

Atlantoaxial Instability (include neurologic symptoms) \_\_\_\_\_

Coxa Arthrosis \_\_\_\_\_

Cranial Deficits \_\_\_\_\_

Heterotopic Ossification/Myositis Ossificans \_\_\_\_\_

Joint subluxation/dislocation \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Pathologic Fractures \_\_\_\_\_

Spinal Joint Fusion/Fixation \_\_\_\_\_

Spinal Joint Instability/Abnormalities \_\_\_\_\_

**Neurological**

Hydrocephalus/Shunt \_\_\_\_\_

Sensory Deficit \_\_\_\_\_

Seizure \_\_\_\_\_

Spina Bifida/Chiara II malformation/Tethered Cord/Hydromyelia \_\_\_\_\_

**Medical/Psychological**

Allergies \_\_\_\_\_

Animal Abuse \_\_\_\_\_

Cardiac Condition \_\_\_\_\_

Physical/Sexual/Emotional Abuse \_\_\_\_\_

Blood Pressure Control \_\_\_\_\_

Dangerous to self or others \_\_\_\_\_

Exacerbations of medical conditions (i.e. RA, MS) \_\_\_\_\_

Fire Settings \_\_\_\_\_

Hemophilia \_\_\_\_\_

Medical Instability \_\_\_\_\_

Migraines \_\_\_\_\_

PVD \_\_\_\_\_

Respiratory Compromise \_\_\_\_\_

Recent Surgeries \_\_\_\_\_

Substance Abuse \_\_\_\_\_

Thought Control Disorders \_\_\_\_\_

Weight Control Disorders \_\_\_\_\_

**Other**

Age – under 4 years \_\_\_\_\_

Indwelling Catheters/Medical Equipment \_\_\_\_\_

Medications – i.e. photosensitivity \_\_\_\_\_

Poor Endurance \_\_\_\_\_

Skin Breakdown \_\_\_\_\_

**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**

**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 records for evaluation purposes, and hereby authorizes any personnel of any records to release this information to Good Hope Equestrian Training Center.**

**Consent Plan**

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.

Date: \_\_\_\_\_

Consent Signature: \_\_\_\_\_

Client, Parent, or Legal Guardian