Xenophon Therapeutic Riding Center

P.O. Box 16 • Orinda • CA • 94563
(510) 459-8116

Student Application and Health History

GENERAL INFORMATION

Student:____

DOB:__________ Age:______ Height:______ Weight:_____ Male Female

Address:____

Phone:____________________ Alternative Phone:____________________

Email:____

School:____

Address:____

Phone:____

Parent/Legal Guardian:____________________________________

Address (if different from above):______________________________

Phone:____

Referral Source:______________________________________

How did you hear about our program?____________________________

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications is student currently taking, including over-the-counter medications?

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Describe student's abilities/difficulties in the following areas (include assistance required or equipment needed)

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

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

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GOALS (i.e. why you are applying for participation and what you would like to accomplish):

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PHOTO RELEASE

I ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by Xenophon Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_______________ Date:_______________

Student, Parent, or Legal Guardian