Dream On Curls Riding Center, INC
153 Kirk Meadow Rd
Springfield, VT 05156
802-885-4126
http://www.dreamoncurls.com/

Participant's Application and Health History

To be completed by the Participant or Parent/Legal Guardian

GENERAL INFORMATION
Participant: ____
DOB: __________ **Age:** _____ **Height:** _______ **Weight:** _______ **Gender:** ___M ___F
Address: ____
Phone: ( ) ____________ **E-Mail:** ______________ **Alternative #:** ( ) ____________
Employer/School: ____
Address: ____
Phone: ( ) ____________
Parent/Legal Guardian: ____
Address (*if different from above*): ____
Phone: ( ) ____________
Referral Source: ____
Phone: ( ) ____________
How did you hear about the program? ____

HEALTH HISTORY
DIAGNOSIS: ____ **DATE OF ONSET:** ___________
Please indicate current or past special needs in the following areas:

	Y	N	COMMENTS
VISION			
HEARING			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMINATION			
CIRCULATION			
EMOTIONAL/MENTAL HEALTH			
BEHAVORIAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITION			
ALLERGIES			

Signature: ____ **Date:** ___________
Signed by Participant or Legal Guardian