Crossroads Center
Rena Cross, Executive Director 18252 Road 4 Liberal, Kansas 67901 620-629-5107

Participant's Application and Health History

(to be completed by participant or parent/legal guardian – must be submitted prior to riding)

GENERAL INFORMATION

Participant: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____City_____

State_____Zip_____

Home Phone: _____Work Phone _____ E-mail_____

Other Phone: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address/Phone(if different from above):_____

In case of emergency contact: _____ Phone: _____

_____ Phone: _____

HEALTH HISTORY

Diagnosis _____ Date of Onset:_____

Please indicate your current or past special needs in the following areas:

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

over

MEDICATION *(include prescription, over-the-counter; name, dose and frequency)* _____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

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

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

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

ANY ADDITIONAL INFORMATION (please provide any additional information you think would be helpful to the center in planning riding sessions.)

Signature: _____ Date: _____

Client, Parent or Legal Guardian