Participant Registration
Please Print Legibly

Participant: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Parent-Guardian/Primary Contact: _____

Phone: _____ Phone Type: Cell Home Work

E-mail Address: _____

Parent-Guardian/Secondary Contact: _____

Phone: _____ Phone Type: Cell Home Work

E-mail Address: _____

School or Educational Facility presently attending: _____

In case of emergency (other than parent or guardian listed above):

Contact #1: _____ Phone: _____

Contact #2: _____ Phone: _____

Rider Information
Please Print Legibly

Participant Name: _____ Date of Birth: _____ Age: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

**Please note: Before riding, participants with a diagnosis of Downs Syndrome will be required to provide a doctor's note verifying they are negative on neurological exam for any decrease in neurological function, or of any symptoms consistent with Antlantoaxial Instability.*

Height: _____ Weight: _____

Shunt: Yes No

Seizures: Yes No

If Yes: Type: _____ Controlled? _____ Date of last seizure: _____

Mobility: Independent Ambulation: Yes No

If no: Wheelchair: Yes No Walker: Yes No Braces/AFOs: Yes No

What goals to you hope therapeutic riding can help you/your rider achieve?

_____

_____

_____

_____