



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			

**Please See Other Side**



*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