BUTTERFLY DREAMS FARM

THERAPEUTIC RIDING PROGRAM, INC.
P.O. Box 622 | Watkinsville, GA 30677
www.butterflydreamsfarm.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Participant's Application and Health History

GENERAL INFORMATION										
Participant Name:										
DOB:		Age:		Height:		Weight:		Gender:	◯ M	◯ F
Address:										
School:										

Parent, Legal Guardian, Caregiver 1:					
Address (if different from participant):					
Home Phone:		Cell Phone:		Email:	
Employer:					

Parent, Legal Guardian, Caregiver 2:					
Address (if different from participant):					
Home Phone:		Cell Phone:		Email:	
Employer:					

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			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

REFERRAL SOURCE	
How did you hear about the program?	
May we contact this person/entity? ◯ Yes ◯ No	Phone:

GOALS
Why are you applying for participation? What would you like to accomplish?

SIGNATURE:			
Participant, Parent, or Legal Guardian:		Date:	

PHOTO RELEASE
I consent to and authorize the use and reproduction by Butterfly Dreams Farm 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. ◯ **I Agree** ◯ **I Do Not Agree**

SIGNATURE:			
Participant, Parent or Legal Guardian: *(to be signed in the presence of BDF Staff)*		Date:	