

**Equine Assisted Therapy**

Health, Happiness and Healing through Horses since 1988

Dear Clients and Families:

Thank you for your interest in the Equine Assisted Therapy Riding programs of Horses of Hope Oregon. Our programs are dedicated to ‘health, happiness and healing through horses’ and improving clients’ lives by promoting wellness, enhancing capabilities, and fostering independence.

It is a pleasure to work with you and the participant in our Equine Assisted Therapyprograms. These programs are only possible due to the generosity of the community, donors, and our volunteers. You are welcome to get to know the volunteers and instructors working with your rider.

Horses of Hope Oregon (HOH) has been serving children and adults with challenges through equine assisted therapy since 1988, and you will find our staff to be experienced, skilled, and caring. HOH’s instructors utilize the therapy horses to facilitate interactive games and skill-building movements tailored to each person’s needs. Interactions with horses help people gain independence and self-esteem. We strive to find what each person is capable of and tailor each lesson to the participant’s goals. Therapeutic riding is linked to cognitive and emotional benefits and physical improvements in balance, motor skills, sensory integration, and muscle strength. Our therapy horses allow people to find a sense of connection – these are emotional animals with unedited feelings. There is a straightforward, easy-to-read quality to horses that is comforting. A therapy horse is not just an incredible athlete, but is also non-judgmental, dependable, caring and kind. They can bring emotional stability to our lives and renew confidence in our own abilities.

**When you arrive:** The driveway is on the east side of the stable. Please ***drive slowly*** and watch out for farm equipment, animals, and pedestrians. Proceed to the front of the stable (which faces Cloverdale Drive) where you will find parking.

**Once inside:** You will find a signup sheet on the table in the foyer. Please sign in as soon as you arrive. ***Everyone*** in your party must sign an inherent risk waiver, which is also on the table.

**Stay in the designated areas:** Remember this is a working stable and although we maintain a warm and friendly environment, it is not appropriate to pet or feed the horses without consent. Our work here is fun and easily generates excitement for siblings. Please remember to keep siblings safe by staying in the designated areas. Please walk quietly or sit quietly at the facility. No running please.There is no childcare, although we do have a playroom with lots of toys and books.

We hope that you have begun to feel the spirit of hope, joy and delight that we generate here at HOH. We look forward to seeing you soon.

Sincerely,

***The Staff at Horses of Hope***

**Riding Schedule and Fees**

**Evaluation**

HOH’s professionals will discuss our Equine Assisted Therapy programs with you. We first schedule a (no fee) Meet & Greet appointment. The purpose of this on-site appointment is for the client to visit the Stable, meet our staff and therapy horses, and discuss objectives, needs, and goals for Equine Assisted Therapy.

**Sessions**

The cost for each equine therapy lesson is $40.00. The annual Equine Assisted Therapy schedule consists of four terms: Winter-Spring-Summer-Fall, with a 2 week break between each session. HOH also closes for Thanksgiving week during the Fall term. Lessons are 30 minutes in length, with an additional 10 minutes used for the family and our Equine Therapy instructor to meet and exchange information and updates, or for clients to spend ground time with their therapy horse. Lessons are held Tuesday through Saturday.

The lesson fee is $40.00, with each term pre-paid a month at a time.

The payment for **each month** will be due in full at the first therapy lesson.

Example: 3 Lessons in the month of December on the 2nd, 9th and the 16th.

$120.00 due on December 2nd

If you cannot attend a lesson, please contact HOH as soon as possible. We understand that we serve an often fragile population and will work with you on an individual basis if you must cancel with less than 24 hours notice for a medical emergency. Any other cancellation with less than 24-hours’ notice, or a no show/no call will result in a $50.00 charge. To help things run smoothly, if you need to cancel, please do so as soon as you know you cannot attend your therapy lesson.

**Scheduling**

Your riding schedule will be **pre-confirmed** with you at the beginning of each week. Please know that a no/show or no/call for reasons other than a medical emergency will result in being charged for the therapy lesson.

We are doing everything we can to keep client fees as low as possible, including subsidizing 60% of the cost of these lessons. If your participant meets Medicaid eligibility and your family needs financial assistance to help pay for the lessons, there may be partial scholarships available on a limited basis. For additional information regarding scholarships, please contact HOH’s office.

**Lesson Vouchers (Gift Certificates)**

Friends and family can help pay for lessons or terms. We can bill them directly or you may suggest that they purchase Lesson Vouchers (Gift Certificates) for riding lessons through HOH’s office. Please call Horses of Hope’s office at (503) 743-3890 with any questions.

**CLIENT INFORMATION SHEET**

The following information will be used by HOH, to help create the most appropriate riding situation possible for prospective clients. Please answer these questions carefully and honestly to the best of your ability. If you do not understand a question, please don’t hesitate to call and ask for assistance at 503-743-3890. If you find a question that does not apply to your situation, write N/A for non-applicable.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client name:** | | | |  | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | | |
| **City:** |  | | | | | **State:** | | |  | | | | **Zip:** |  |
| **Phone:** |  | | | | | | |  | | **Cell:** |  | | | |
| **E-mail:** |  | | | | | | | | | | | | | |
| **Height:** |  | | | | | | **Weight:** | | | | |  | | |
| **Date of Birth:** |  | | | | | | **Sex:** | | | | | F  M | | |
| **Therapist (PT / OT / SLP):** | | | | |  | | | | | | | | | |
| **Therapist phone:** | | |  | | | | | | | | | | | |
| **Ethnicity:** | African American Asian  Caucasian Latino  Pacific Islander Alaska Native/Native American  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I Prefer Not To Disclose | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Responsible Financial Party Name:** | | |  | | | | | | |
| **Relationship to Client:** |  | | | | | | | | |
| **Address:** |  | | | | | | | | |
| **City:** |  | **State:** | | |  | | | **Zip:** |  |
| **Phone:** |  | | |  | | **Cell:** |  | | |
| **E-mail:** |  | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | | | |
|  | | | |
| **Print full name:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |  |

Photo taken within the last 12 months

PHOTO

Application is **NOT** complete without a photo. Incomplete applications cannot be processed.

PLEASE COMPLETE, SIGN AND RETURN:

1. **Client Information Form**
2. **Client Questionnaire**
3. **Client Orientation Form**
4. **Participant Agreement**
5. **Request & Release**
6. **Photo Agreement**
7. **Confidentiality Agreement**
8. **Emergency Preparedness Form**
9. **Riding Schedule and Fees**

PLEASE RETURN COMPLETED APPLICATION TO:

**Horses of Hope Oregon**

**2895 Cloverdale Drive SE**

**Turner, OR 97392**

For office use only:

Date received \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLIENT QUESTIONNAIRE**

Please fill out this page so that we know if you have any conditions that could affect your balance, health, or safety while riding.

|  |  |  |
| --- | --- | --- |
| **DIAGNOSIS OR DISABILITY:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **IS CLIENT AMBULATORY:** | Y  N | |
| **ADAPTIVE APPLIANCES USED: (wheelchair, crutches, etc.)** |  | |
| **SEIZURES:** | Y  N | |
| **Explain**: | | |
| **CONTRACTIONS**: | Y  N | |
| **Explain:** | | |
| **SPASTICITY:** | Y  N | |
| **Explain:** | | |
| **FUSIONS:** | Y  N | |
| **Explain:** | | |
| **FRAGILITY:** | Y  N | |
| **Explain:** | | |
| **FATIGUE:** | Y  N | |
| **Explain:** | | |
| **PRESSURE SORES?** | | Y  N |
| **CAN CLIENT SIT WITHOUT SUPPORT?** | | Y  N |
| **CAN CLIENT TRANSFER WITHOUT HELP?** | | Y  N |
| **DOES CLIENT TIRE EASILY?** | | Y  N |
| **HAS CLIENT RIDDEN BEFORE?** | | Y  N |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VISION:** | Good | Fair | Poor | None |
| **HEARING:** | Good | Fair | Poor | None |
| **SPEECH:** | Good | Fair | Poor | None |
| **BALANCE:** | Good | Fair | Poor | None |
| **NECK STRENGTH:** | Good | Fair | Poor | None |
| **ARM STRENGTH:** | Good | Fair | Poor | None |
| **HAND DEXTERITY:** | Good | Fair | Poor | None |
| **EYE HAND COORDINATION:** | Good | Fair | Poor | None |
| **TRUNK STRENGTH:** | Good | Fair | Poor | None |
| **LEG STRENGTH:** | Good | Fair | Poor | None |
| **HIP FLEXION:** | Good | Fair | Poor | None |

|  |  |  |  |
| --- | --- | --- | --- |
| **RATE PAIN SENSITIVITY:** | Normal | Above Normal | Below Normal |
| **RATE HEAT SENSITIVITY:** | Normal | Above Normal | Below Normal |
| **RATE COLD SENSITIVITY:** | Normal | Above Normal | Below Normal |
| **RATE SENSITIVITY TO TOUCH OR TEXTURES:** | Normal | Above Normal | Below Normal |

|  |
| --- |
| **Additional Information:** (use additional page(s) if necessary) |
|  |

**CLIENT ORIENTATION**

**Carefully read, sign, and return. If you do not understand the information provided, please ask our staff to explain.**

* All clients, parents, and guardians are required to read and sign a liability waiver prior to participation.
* Please keep children under your control at all times.
* **Maximum weight is 200 pounds**. Clients exceeding this weight limit will have to meet with staff to discuss full participation.
* Pets permitted with **pre-approval**, and must be on a leash at all times! Please clean up after your pet.
* Only one client per horse.
* **Long pants** are recommended.
* **Closed-toed shoes with a heel** are required (no sneakers or sandals please).
* Recreational use of drugs or alcohol is ***not*** allowed prior to or during equestrian activities.
* Horses of Hope Oregon staff and volunteers will not discriminate on the basis of a client’s race, religion, gender, age, national origin, ancestry, economic status, or mental or physical disability.
* If minors participate unaccompanied by a parent or guardian, the staff shall have full authority with regards to the minor’s behavior, participation, and emergency medical treatment.
* Each client must wear an A.S.T.M. approved equestrian helmet before mounting. If you don’t have a helmet, we will provide you with one.
* If you have any questions regarding these procedures, please discuss them with staff prior to the beginning of your ride. Your participation in this activity signifies full acceptance of all rules and conditions.
* Your cooperation will help us to provide an enjoyable horseback adventure.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of client, parent, or guardian:** | | | |
|  | | | |
| **Print full name:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |  |

**PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK**

In consideration of the services of Horses of Hope Oregon, their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as ‘HOH’), I hereby agree to release, indemnify, and discharge HOH, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that horse activities entail known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

**The risks include, among other things**: contact with wild animals, hiking and exposure to the elements. A horse, regardless of its training and usual past behavior, may act unpredictably at times based upon instinct or fright which may cause you to be thrown from your horse or injured by the horse. Horses may do such things as bite, kick, buck, lie down, or stumble. Saddles may slip and other tack or saddle problems may develop as a result of normal use and wear. Your horse may collide with obstacles or encounter variations in terrain such as creeks, water, bridges, traveled roads, wild animals, birds, stump, forest growth, debris, rocks and cliffs and other obstacles whether obvious or not and whether man made or natural. Each of those obstacles or variations in terrain could cause you to lose control of your horse and you could fall. Riding a horse requires the participant to balance on the saddle. Participants may lose their balance that can result in falling from the horse.

Furthermore, HOH employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They might misjudge the weather or other environmental conditions. They may give incomplete warnings or instructions, and the equipment being used might malfunction.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless HOH from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of HOH's equipment or facilities, **including any such claims which allege negligent acts or omissions of HOH**.

4. Should HOH, the property owner, or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I certify that I have adequate insurance to cover any injury or damage I may suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

6. In the event that the lessee files a cause of action against HOH, the lessee agrees to do so solely in the state of Oregon, and further agrees that the substantive law of that state shall apply in that action without regard to the conflict of law rules of that state. The lessee agrees that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

**By signing this document, I acknowledge that if I am hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against HOH, its staff, Board of Directors, Therapists, volunteers, and Property Owner on the basis of any claim from which I have released them herein.**

**I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.**

Signature of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eve: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION**

**(Must be completed for participants under the age of 18)**

In consideration of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print minor's name)

("Minor") being permitted by HOH to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless HOH from any and all Claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTO AGREEMENT**

I, the undersigned, grant to Horses of Hope Oregon, hereafter referred to as ‘HOH’, and/or their assignees permission in perpetuity throughout the world to use my likeness, performance, recording, and/or voice as photographed and/or recorded by them for still or motion picture uses, internet - including website and Facebook, or any other use connected with the promotion, exhibition, marketing or benefit of ‘HOH’s’ programs.

I hereby release HOH, its assignees, licensees, and successors including, but not being limited to, all networks, stations, sponsors, publishers, distributors and exhibitors from any and all claims, liabilities, demands, or causes of action which I have or may hereafter have, by reason of photographing, recording, broadcast, exhibition, or any other uses of such films or recordings that may be from time to time made, or by reason of any occurrence or circumstance that may have taken place in or in conjunction with the photographing or recording of any scenes.

The undersigned further agrees that HOH shall own all rights, title and interest including any copyright in and to anything produced pursuant to the right granted HOH and that this waiver and release is binding on the heirs of the undersigned.

**PLEASE PRINT**

Participant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AFFIRM THAT I AM MORE THAN 18 YEARS OF AGE**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If participant is less than 18 years of age, parent or guardian must complete the following guardian consent.

I am the parent or guardian of the above mentioned participant. I hereby approve the foregoing and consent to the terms mentioned above. I affirm that I have the legal right to issue such consent.

PLEASE PRINT

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_

Zip \_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality Agreement**

**I understand that each client’s pertinent medical information may be discussed between staff and volunteers for the participant’s safety and benefit. We keep a record of each person’s medical diagnosis / disability / challenge. This allows staff to be informed of any special safety issues. Individualized emergency plans are developed accordingly. Riding lessons are also individualized based on the client’s medical needs.**

**Any information regarding the participants (clients) at Horses of Hope Oregon will be held in strict confidentiality. For the purposes of grant funding and public relations, the client’s success story may be shared at public meetings or conferences, with identity protected. Photos will only be shared with the client’s permission (written photo release).**

Signature of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION**

**(Must be completed for participants under the age of 18)**

In consideration of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print minor's name) ("Minor") being permitted by HOH to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless HOH from any and all Claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY PREPAREDNESS CARD**

|  |  |
| --- | --- |
| **NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DATE OF BIRTH:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **CONTACTS & PHONE #’S (RELATIONSHIP):**  1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **MEDICAL INFORMATION & HISTORY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PHYSICIAN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ALLERGIES / ASTHMA**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **HEALTH CARE PLAN (S):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ALLERGIES TO MEDS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT MEDICATION**:

|  |  |  |
| --- | --- | --- |
| **NAME OF MEDICATION** | **AMOUNT** | **HOW OFTEN?** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

**Print Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**