Special Equestrians, Inc.

Annual Updating Form for Participants

Name: _____ Date: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____ Email: _____

Employer/School: _____

Parent/Legal/Guardian/Caregiver_____Address/Phone_____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies (medicines, food, environmental, insects, plants): _____
In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, Special Equestrians, Inc. will determine if emergency services should be contacted. The injured adult or legal guardian/parent has the right to refuse treatment from the emergency responders; however Special Equestrians will call for emergency medical treatment services, when it is deemed necessary by our staff.

In the event of needed emergency medical treatment, Special Equestrians will:

1. Secure and retain medical treatment and transportation if needed.
2. Release records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Participant, Volunteer, Staff, Parent or Legal Guardian

PLEASE TURN OVER OR GO TO 2ND PAGE

PLEASE INDICATE 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			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency)

_____

_____

WEIGHT_____

Describe your (or your child's) 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/bus riding)

_____

_____

_____

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

_____

_____

_____

GOALS (What would you (or your child) like to accomplish in the coming year?)

_____

_____

_____

Any changes not covered in this document:

_____

_____

►Client/Parent/Guardian/Caregiver Signature _____ **◄ Date** _____