TRI STUDENT APPLICATION

There will be a $25 application fee due at the time of your evaluation. This can be paid via cash or check made payable to the Therapeutic Riding Institute.

Participant Name _____ DOB ____ Age _____ Gender F ◯ M ◯ Identifies _____

Participant is a: Minor ◯ Adult w/ Guardian ◯ Independent Adult ◯

Parent/Guardian Name _____

Primary Telephone _____ Email _____

Full Mailing Address _____

Is Participant in School? Y ◯ N ◯ Home Schooled? Y ◯ N ◯ Grade Level _____

Special Needs Typical Class

How did you hear about TRI? _____

For Grant Purposes:

◯ African American ◯ Asian ◯ Caucasian ◯ Hispanic/Latino ◯ Native American ◯ Other

◯ Veteran ◯ Dependent of Veteran ◯ Qualified for County Vouchers Not Applicable ◯

_____

HEALTH HISTORY

Current Height _____ Weight _____ Ambulation: ◯ Independent ◯ Walker ◯ Wheelchair

Primary Diagnosis _____

* ASD Level _____

Secondary Diagnosis _____

Precautions _____

Current Therapies and How Often: PT ◯ OT ◯ Speech ◯ Behavioral ◯ Psychotherapy ◯

MARK ALL THAT APPLY

Non-Verbal		Catheter		Aggressive		Communication Device	
Limited Eye Contact		Cochlear Implants		Bites		Leg/Foot Brace	
Allergies		Feeding Tube		Hits		Needs Support to Sit Up	
ALS		Hearing Aids		Grabs		Poor Balance Standing	
Asthma		Seizures		Screams		Poor Balance Sitting	
Service Dog		Shunt				Waist Belt	

IN THE PAST 12 MONTHS, HAS THE PARTICIPANT EXPERIENCED ANY OF THE FOLLOWING

YES	ISSUE	DATE	EXPLANATION
	Loss of consciousness, including seizures		
	Hospitalized for mental health crisis		
	Hospitalized (injury, surgery, etc.)		
	Activities been restricted due to medical reasons		

Yes	Participant with or is Treated For:	Date(s)	Comments
	Brain Condition i.e., Cerebral Palsy, stroke		
	Spinal Condition i.e., Spina Bifida, Scoliosis, Fusion, Injury		
	Medical Device Implanted (insulin pump, catheter, colostomy)		
	Seizure Disorder *Be very specific to type.		
Yes	**Participant with or is Treated For:**	**Date(s)**	**Comments**
	Joint complications i.e., dysplasia		
	Bleeding or clotting disorders		
	Heart Condition		
	Neurological condition		
	Muscular Disorder		
	Epilepsy		
	Mental Health Crisis		
	Pulmonary condition		
	Violent Outbursts		
	Have altered sensation? (specify)		

GOAL – WHAT DO YOU EXPECT TO BE ACCOMPLISHED WITH EQUINE ASSISTED ACTIVITIES

AREA and EXAMPLES	SPECIFY
PHYSICAL (strength, balance, fine motor, gross motor ….)	
BEHAVIORAL (reduce frustration or aggression, express self ….)	
COGNITIVE (follow directions, engage higher function senses ….)	
RECREATIONAL (fun, exercise, peer interaction ….)	
OTHER GOALS	

Anything else you would like us to know about this participant that will enable us to support them through Equine Assisted Activities:

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I confirm that the information provided is accurate and true as it pertains to the listed participant,

_____

Name of Person Completing Form Signature Date

For Office Use Only: Evaluation Scheduled: _____ Staff Assigned: _____

Precaution/Contraindication: _____

Follow Up: _____

Possible Program: _____ Confirmed: _____