HEALTH DIRECTED RIDING, INC.

Where Rehab Reins

Youth Rider Application

Rider's Name: _____ Date of Birth _____ Age: ___
Mailing Address:
_____
_____
City State Zip

Parent/Legal Guardian _____
address (if different than above):_____
Phone: (H) _____ (W) _____ (Cell) _____ Email:
_____
Rider's Weight _____ Height _____ Primary Disability _____

Motor Function:
Mobility:
_____ Able to walk normally without assistance or special devices:
_____ requires assistance or special devices. Please specify: _____
_____

Transfers:
_____ No assist needed
Transfers with: _____ assist of 1 _____ assist of 2 _____ assist of 3 or more
There are structural problems or absence of the following body parts: _____
_____
Are any joints limited in range of motion/mobility? _____ NO _____YES if yes, describe: _____

My child is able to do the following by him/herself without special support:

_____ Roll	_____ sit on floor	_____ no impairment
_____ belly crawl	_____ creep on hands & knees	_____ knee walk
_____ sit on chair	_____ stand without support	_____ walk
_____ stand by furniture	_____ climb stairs	

_____balance impaired Describe specifically: _____
_____

Hand function:
_____ No impairment
_____ Function is impaired. My child uses his/her _____right _____left hand best.
_____ My child uses one hand MUCH better than the other.
_____ My child uses both hands about the same.
Can your child pick up a small object (i.e. raisin) with thumb/finger tip? _____YES _____ NO

Does your child have a special problem with brittle bones or fractures? _____ NO _____ YES, (describe)
_____
_____

Does your child have any loss of or delayed response to the sensation of pain, temperature, etc?
_____ NO _____ YES, (describe): _____
_____

Toileting:
_____ Totally independent
_____ Needs assistance. How does your child indicate need: _____
_____

Communication Skills:
Communicates to others by:
_____ Speaking in sentences
_____ Uses 1-2 word phrases
_____ Uses alternative means of communication (pointing, signing, looking at object, language board, etc.)
Describe: _____
_____
My child understands: _____ complex directions _____ simple directions _____ single words
_____ sign language _____ has delayed response to directions

Vision and Hearing
Visual skills:
_____ Normal
_____ Impaired _____ corrected with glasses _____ legally blind _____ cortical blindness
_____ other (describe)_____

Hearing ability:
_____ Normal _____ Impaired (indicate degree) _____
_____ Hearing aid Auditory level set at: _____
_____ Test results inconclusive

Learning Ability:
My child's learning ability is: ___ above average ___ average ___ slightly below ___ significantly below
My child learns best: _____ by most common teaching methods _____ by total communication
_____ in a few select ways (describe) _____

Behavior:
My child's response to new situations/people is: _____ open/receptive _____ warms up gradually
_____ hesitant _____ resistive/fearful passive/little response

In learning situations my child is usually: _____ cooperative _____ variable _____ uncooperative
My child: _____ has no special fears _____ fears the following (describe) _____
_____

Other:
Seizures: _____ have never been a problem _____ were in the past but not in the last two years
_____ are controlled by medication _____ are not controlled completely, Describe type, frequency and Management: _____
_____

Medications:
_____ Takes no medication
Takes the following medication(s): _____
Describe any operations your child has had: _____
_____

What allergies, if any, does child have? _____

What are your child's strengths or best areas of function: _____
_____

How do you hope your child will benefit from the therapeutic horseback riding program? _____
_____
If necessary would you allow your child to be screened at no cost to you by the registered physical / occupational therapists associated with Health Directed Riding? _____YES _____ NO

Is your child currently involved in any program for children with special needs _____ YES _____ NO
If yes, indicate name and location of school, therapist, etc. _____
_____
_____
May we contact staff at your child's school /program to obtain information about child's strengths and weaknesses? _____ YES _____ NO

Does your child have any previous horseback riding experience? _____ YES _____ NO

What else would you like us to know about your child: _____
_____
_____
_____
Who filled out this form? _____ Relationship to rider _____
Child's physician: _____

Dated this _____ day of _____, 20_____.
Signature:_____
Parent/Legal Guardian if above is under 18 or unable to sign

Please return this completed form to:

Health Directed Riding, Inc.
PO Box 335, Grandy, MN 55029