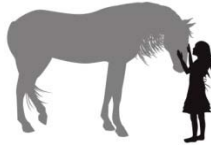


SERENDIPITY EQUINE HAVEN



Where Dreams Are Born and Hopes Are Raised

Participant/Rider/Athlete Registration Form

First Name: _____ Last Name: _____

Preferred Nickname: _____ Birth Date: _____ Sex: M____ F____

Parent(s)/Legal Guardian(s): _____

Address: _____ Apt #: _____ City: _____ ST: _____ Zip: _____

Home #: (____) ____ - _____ Cell #: (____) ____ - _____ Work #: (____) ____ - _____

E-mail: _____

Please answer the following questions regarding the Participant/Rider/Athlete:

Participant/Rider/Athlete Diagnosis: _____

When was the participant/rider/athlete diagnosed?

Birth: _____ Result of an Accident: _____ Date of Accident: _____ Other: _____ Date: _____

Does the participant/rider/athlete use any of the following?

Wheelchair _____ Cane _____ Walker _____ Crutches _____ Braces _____

Other (Please Explain)

Has the participant/rider/athlete ever been involved in therapeutic horseback riding before? Yes _____ No _____

If yes, how long ago has it been? _____

**INFORMATION ON THIS FORM MAY BE USED IN THE PREPARATION OF GRANT APPLICATIONS FOR PROGRAM FUNDING;
HOWEVER, NAMES WILL BE STRICTLY CONFIDENTIAL.**

Other extra-curricular types of therapy the participant/rider/athlete uses or has used in the past:

Do you or your child have any particular goals you wish to achieve through this program?

Are there any special instructions that may help us in achieving your goals?

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