

UCP SADDLE PALS  
P.O. Box 1565  
Orangevale, CA 95662  
(916) 988-7734

## PARTICIPANT'S APPLICATION FORM

*To be completed by the parent/legal guardian or participant*

**Applicant Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
\_\_\_\_\_  
**Alternate #:** \_\_\_\_\_  
**School attending:** \_\_\_\_\_ **Grade level:** \_\_\_\_\_  
**Parent(s)/Guardian(s):** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
\_\_\_\_\_  
**Alternate #:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Gender:** M \_\_\_ F \_\_\_

Current medications/Notable side affects

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PLEASE COMMENT ON EACH APPLICABLE AREA BELOW:

**Allergies:** \_\_\_\_\_  
**Seizures:** Yes \_\_\_ No \_\_\_ **Type:** \_\_\_\_\_  
If yes, are they controlled: Yes \_\_\_ No \_\_\_  
Please comment on frequency and duration of seizure activity: \_\_\_\_\_  
\_\_\_\_\_

Does the applicant have a shunt? Yes \_\_\_ No \_\_\_

If Down Syndrome, has the applicant had AAI radiographs? Yes \_\_\_ No \_\_\_

If yes, do you know the results? Positive \_\_\_ Negative \_\_\_

**Scoliosis:** Type of curvature: \_\_\_\_\_ Degree of curvature: \_\_\_\_\_

**Vision:** \_\_\_\_\_

**Hearing:** \_\_\_\_\_

**Sensory Awareness:** \_\_\_\_\_

**Communication:** Primary means/level: \_\_\_\_\_

Has applicant been around horses before? Yes \_\_\_ No \_\_\_

If yes, please describe the applicant's reactions/experiences: \_\_\_\_\_  
\_\_\_\_\_

Is the applicant comfortable being around animals? Yes \_\_\_ No \_\_\_

Over ----->

**PHYSICAL FUNCTION**

Physical Mobility:     Uses wheelchair only                       Walks with assistive device(s)  
                                  Walks independently                       Other: \_\_\_\_\_  
Sitting Balance:     Sits without trunk support                       Must have trunk support at all times  
                                  Sits for a limited time without trunk support - \_\_\_\_\_ (minutes)

Postural Balance: \_\_\_\_\_

Muscle Tone: \_\_\_\_\_

Gross motor coordination: \_\_\_\_\_

Fine motor coordination: \_\_\_\_\_

**PSYCHOSOCIAL FUNCTION**

Behavior: \_\_\_\_\_

Relationships (i.e., family, friends, companion animals, support systems, etc.): \_\_\_\_\_

Fears/concerns: \_\_\_\_\_

**GOALS**

Are there specific goals or skills you wish for the applicant to strive toward? \_\_\_\_\_

Is there any additional information that will help us when working with the applicant? \_\_\_\_\_

Does the applicant currently receive services from a therapist?    Yes \_\_\_\_\_    No \_\_\_\_\_

What type of therapy? \_\_\_\_\_

May we contact your therapist to discuss participation in this program? Yes \_\_\_\_\_    No \_\_\_\_\_

If yes, please provide name and phone number: \_\_\_\_\_

How did you hear about Saddle Pals? \_\_\_\_\_

Signature of person completing this form

Date