Beyond Reins
WOMEN'S EQUINE PROGRAM

WELLNESS FORM

PARTICIPANT INFORMATION

Full Name :
(PLEASE PRINT)

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Allergies : ____

Diagnosis (if applicable) : ____

Daily Medications : ____

Behavioral Need : ☐ ADD/ADHD ☐ Autism ☐ Post-Trauma ☐ Anxiety/Depression ☐ Addiction

☐ **Other Mental Health Concern(s)/Disorder(s)/Hospitalizations** ____

PHYSICIAN NAME : ____ **Medical Insurance** : ☐ Yes ☐ No

PHYSICIAN PHONE : ____ **CLIENT OPEN TO REFERRAL** : ☐ Yes ☐ No

EMERGENCY CONTACT DETAILS

Contact Name : ____ **Home Number** : ____

Relationship : ____ **Mobile Number** : ____

EMERGENCY & MEDICAL RELEASE

☐ I release all personnel, facility owner(s), and respective supervising individuals from all legal responsibility and litigation in the event of accident, injury, illness, or other emergency situation.

☐ I consent to the administration of proper medical attention necessary for my child(ren) in the event of emergency, INCLUDING basic OTC medications such as Benadryl, Tylenol, and Ibuprofen.

☐ I commit to protecting the privacy of all persons involved in any accident, emergency, or related events associated with this organization.

Date : ____ **Signature** : ____