Taylor Farms
480 Bishop Rd
Ball Ground, GA 30107
taylorfarmsga@gmail.com
678-683-0909
taylorfarmsga.com

DATE (mm/dd/yyyy)	

CLIENT INFORMATION

First Name		**Middle Initial**		**Last Name**	

Sex	Male		Female		**DOB** (mm/dd/yyy)		**Height** (in.)		**Weight** (lbs.)	

Medical Conditions:	

Date of Onset (mm/dd/yyyy)		**Hand Dominance**	Right		Left		Not Established	

Allergies	

Language	Primary		Secondary, *if any*	

PARENT/GUARDIAN INFORMATION

Parent		**Guardian**		**Foster Parent**		

Mother's Name		**Father's Name**	
Mother's Cell		**Father's Cell**	

Email		**Home Phone**	

Street Address	

City		**State**		**Zip Code**	

EMERGENCY CONTACT

Name		**Relationship**		**Phone**	

CONSENT OF TREATMENT

I consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician and/or surgeon; or any x-ray, examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a licensed dentist. This authorization shall remain effective until my child completes his/her activities in this program unless sooner revoked in writing. I understand that as a parent/guardian, I will be responsible for the cost of any service or treatment provided.

By signing this form, I acknowledge that I have read and understand the contents and am competent to execute it or if executed on behalf of another, that I am authorized to execute it on behalf of that person.

Parent/Guardian Signature		**Date**	

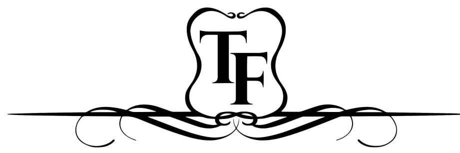


PHOTO RELEASE

I hereby consent to and authorize the use and reproduction of any and all photographs and other audiovisual materials taken of me, my son, daughter or ward for promotional printed material and/or educational activities for Taylor Farms program.

Parent/Guardian Signature		**Date**	

RELEASE AND INDEMNIFICATION AGREEMENT

Be it known that under Georgia Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

____(Client's Name) would like to participate in the Taylor Farms program. I acknowledge the risks and potential for risks of horseback riding/driving programs. However, I feel that the possible benefits to me/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, indemnify, hold harmless, waive and release forever all claims for damages against Taylor Farms its Board of Directors, Instructors,. Therapists, Aides, Volunteers and/or Employees, as well as the owners of the property, Taylor Farms, their officers and family members, agents, employees, and contractors for any and all injuries and/or losses, including theft, loss of property, or death that I may sustain while participating in the Taylor Farms program.

Parent/Guardian Signature		**Date**	

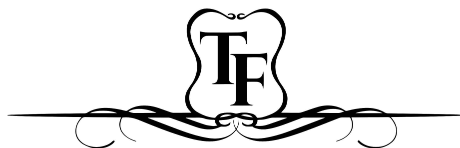
MEDICATIONS

Name	Dosage	Frequency	Reason

SURGERIES AND PROCEDURES

Surgery	Date	Doctor

Is there a history of seizures?	No		Yes		If yes, explain.	
Down Syndrome: Negative x-ray for atlantoaxial instability?	No		Yes		Date of x-ray	



MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No
Abnormal Fatigue			History of skin breakdown (If yes, please explain.)		
Acute Arthritis					
Acute Herniated Disk			Hydrocephalus		
Agitation with severe confusion			Implanted Devices		
Allergies dust, mold, hay, etc			Incontinence		
Aneurysm			Loss of sensation		
Arnold Chiari Malformation			Multiple Sclerosis, acute		
Asthma			Open wounds		
Audible Aspiration			Osteogenesis Imperfecta		
Cardiac/Heart condition			Osteoporosis		
Circulation problems			Obesity Problems		
Complete quadriplegia			Recent Dorsal Rhizotomy		
Degeneration of hip joint			Scoliosis greater than 30 degrees		
Diabetes			Seizure disorder		
Excessive swayback/hunchback			Shunt(s)		
Feeding Tube			Spinal fusion		
Food Allergies (If yes, to what?)			Spondylolisthesis		
			Silent Aspiration		
Grafts over bony/weight bearing areas			Substance Abuse		
Head injury			Tethered Cord		
Hearing problems			Tracheostomy		
Hemophilia/Blood disorder			Unstable neck or spine		
Heterotrophic Ossification			Vision problems		
Hip dislocation, subluxation, or dysplapsia			Other		

GOALS/EXPECTATIONS

What do you hope to achieve through our services? What goals would you like to see accomplished?