REININGHEROES@YAHOO.COM
REINING★HEROES
COLORADOREININGHEROES.COM
Therapeutic Riding and Beginning Horsemanship

Reining Heroes, Inc.
Rider Application/Registration

Participant Name _____ Date _____

D.O.B._____ Age _____ Height _____ Weight _____ M F

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Work Phone_____

E-mail Address _____

School or Current Employer _____

Parents/Legal Guardians/Caregivers

#1 _____ Cell Phone _____

#2 _____ Cell Phone _____

Address (if different from above) _____

Emergency Contact (other that parents/guardians/caregivers) _____

Relationship _____ Cell Phone _____

How did you hear about us? _____

HEALTH HISTORY

Diagnosis_____ Date of onset _____

Please indicate past or current special needs in the following areas:

_____Vision	_____Hearing	_____Sensation	_____Communication
_____Heart	_____Breathing	_____Digestion	_____Elimination
_____Circulation	_____Allergies	_____Behavioral	_____Thinking/Cognition
_____Pain	_____Bone/Joint	_____Muscular	_____Emotional/Mental Health