CLIENT APPLICATION AND MEDICAL HISTORY
LOVING ANGEL SERVICE DOGS, INC.
CHILD/ADULT WITH GUARDIAN

PLEASE PRINT CLEARLY DATE _____

MOTHER:

First Name _____Last Name _____

Street Address _____

City _____State _____ Zip _____

Home Phone (w/area code) _____Cell Phone (w/area code) _____

E-Mail _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer _____ Work Phone _____

FATHER:

First Name _____Last Name _____

Street Address _____

City _____State _____ Zip _____

Home Phone (w/area code) _____Cell Phone (w/area code) _____

E-Mail _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer _____ Work Phone _____

CHILD/DEPENDANT:

First Name _____Last Name _____

Street Address _____

City _____State _____ Zip _____

Home Phone (w/area code) _____Cell Phone (w/area code) _____

E-Mail _____

Date of birth (mm/dd/yyyy) _____Age _____ Gender ☐ M ☐ F

Approximate weight _____Approximate height _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Emergency contact (not parent) Name _____

Street Address _____

City _____State _____ Zip _____

Home Phone (w/area code) _____Cell Phone (w/area code) _____

E-Mail _____

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PHYSICIAN INFORMATION

Name _____Type of practice _____

Phone (Including area code) _____

City _____State _____ Zip _____

Is your doctor available for a consultation regarding this application? ☐ Yes ☐ No

LIVING INFORMATION – When families are split, list primary information here and attach a separate list for the other household answering all these questions.

What type of residence does the child live in? ☐ House ☐ Apt ☐ Other (explain)

_____

With whom do they live? (check all that apply)

☐ Alone ☐ Parent(s) ☐ Spouse ☐ Siblings (Ages) _____ ☐ Attendant

Does anyone else living with them have a physical or mental disability? ☐ Yes ☐ No

If yes, how are they disabled and what are their limitations?

_____

Is anyone allergic to dogs? ☐ Yes ☐ No

Primary means of transportation:

☐ Family vehicle ☐ Friends ☐ Public transportation (Bus Cab)

Animals in the household: _____Dogs _____Cats Other (explain) _____

If your present pets do not get along with your Loving Angel, are you willing to give them up?

☐ Yes ☐ No What arrangements would you make? _____

_____

Please check all that describe your residence:

☐ Fenced Yard How tall is fence? _____ ☐ Enclosed outside area

☐ Park or yard nearby ☐ Neighbors in close proximity ☐ Busy streets nearby

☐ Neighborhood dogs running loose

If you don't have a fenced yard, can you put one up before receiving a dog? ☐ Yes ☐ No

DISABILITY INFORMATION

What is the primary disability? _____

Please list secondary disabilities, if any _____

What caused the disability or disabilities? _____

If caused by an injury, what progress has been made since the injury? _____

_____

_____

How does it affect their daily living (limitations)? _____

_____

_____

How long have they been disabled? _____

Is the disability progressive? ☐ Yes ☐ No

Are there any current changes in the disability? ☐ Yes ☐ No

If yes, explain

_____

What are the effects of the disability? (check all that apply)

☐ Deafness ☐ Speech Impairment ☐ Reduced Stamina ☐ Hearing Loss ☐ Spasticity

☐ Limited Mobility ☐ Muscular Weakness ☐ Slow Development ☐ Vision Impairment

☐ Memory Loss

Please rate their ability to do the following tasks:

	Normal	Medium Difficulty	Very Difficult	Unable To Do
Pick up an item off the floor	☐	☐	☐	☐
Hold an item in your hand	☐	☐	☐	☐
Push an elevator button	☐	☐	☐	☐
Open interior doors	☐	☐	☐	☐
Open exterior doors	☐	☐	☐	☐
Flex your wrist	☐	☐	☐	☐
Speak in different tones	☐	☐	☐	☐

What is the total weight they can lift in pounds with:

Right arm? _____Left arm? _____

Do they have problems with any of the following? (check all that apply)

☐ Allergies ☐ Chronic pain ☐ Depression ☐ Balance ☐ Fatigue ☐ Brittle Bones

☐ Heightened Emotions ☐ High Blood Pressure ☐ Skin Sensitivity ☐ Heat/Cold Sensitivity

Indicate any assisting devices they use (check all that apply)

☐ Leg Brace ☐ Wheelchair ☐ Electric Wheelchair ☐ Walker ☐ Electric Scooter

☐ Crutches ☐ Cane ☐ Hearing Aid ☐ Prosthesis (specify) _____

Other _____

What types of transfer do they use? (check all that apply)

☐ Standing ☐ Pivoting ☐ Slide Board ☐ With Help ☐ Lift or Hoist

Other _____

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How is their speech? (check all that apply)

☐ Clear ☐ Clear-slow ☐ Slurred ☐ Difficult to understand

How do they best communicate? (check all that apply)

☐ Voice ☐ Letter board ☐ Interpreter ☐ Other _____

How far can they walk? (check all that apply)

☐ No Problem ☐ Short Distances ☐ Only with Support ☐ On Level Ground ☐ Not at all

How high can they lift their arms?

☐ Above head ☐ To shoulders ☐ Only slightly

Please rate their ability in the following areas:

	Normal	Somewhat Limited	Very Limited
Voice	☐	☐	☐
Lung Capacity	☐	☐	☐
Hearing	☐	☐	☐

	Excellent	Good	Fair	Poor
Balance	☐	☐	☐	☐
Endurance	☐	☐	☐	☐
Mobility	☐	☐	☐	☐
Physical Strength	☐	☐	☐	☐
Speed of Reaction	☐	☐	☐	☐
Vision (with correction)	☐	☐	☐	☐

	Very Much	Somewhat	Not Very	Not at All
Sensitive to heat	☐	☐	☐	☐
Sensitive to cold	☐	☐	☐	☐
Sensitive to pain	☐	☐	☐	☐
Socially active	☐	☐	☐	☐

With their current health, is it safe for them to travel by? (check all that apply)

☐ Plane ☐ Bus/Public transportation ☐ Drive self ☐ Driven by others

How do they handle the following?

	By self	With Assistance	By others
Medications	☐	☐	☐
Your finances	☐	☐	☐
Housekeeping	☐	☐	☐
Meals	☐	☐	☐
Personal care/ Getting dressed	☐	☐	☐

What personal attendants do they use? ☐ Family members ☐ Personal Care Aide ☐ Medical

☐ Housekeeping Other _____

Number of hours for attendants:

_____ Per Day **or** _____Per Week or _____ Per Month

Explain in more detail *anything* that will better help us to understand your family's needs.

_____

_____

_____

_____

_____

OTHER INFORMATION

What kind of activities are they involved in? (check all that apply)

☐ Work (paid or volunteer) outside the home ☐ Work (paid or volunteer) from within the home

☐ School ☐ Shopping (groceries, clothes, etc.) ☐ Formal exercise

Please describe their home life, social activities, hobbies, and lifestyle in general:

_____

_____

_____

Do they currently receive any government benefits? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ SSI ☐ Veterans ☐ Rehab ☐ Disability

DOG INFORMATION

What kind of dog are you looking for?

☐ Public Access Service dog ☐ In-home skilled dog

How do you think a dog will be able to help them? _____

_____

_____

What skills do you hope the dog will have? _____

_____

In what ways do you think having a dog will help you as a parent/guardian?_____

_____

_____

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Does your child want a service dog? If yes, why? Please write down what they say about this

_____

_____

_____

_____

If you want the dog to go to school with your child, have you discussed this with the teachers and the school administrators? How did they respond? _____

_____

If there are other children in the family, what do they think about this child having a service dog? Because bonding is important, this child should be the only one to feed the dog, give him treats and play with him. This can be very difficult for all of them. How will you handle this potential conflict? _____

_____

_____

Does your child currently have, or ever had a service dog? ☐ No ☐ Current ☐ In the Past

If so, who trained your dog? _____

How many years did the dog partner with them? _____

Having a service dog is an incredible opportunity that can enhance your child's life in many areas – physically, emotionally, spiritually and socially. Along with those benefits come associated responsibilities. As the owner of a service dog, the partnership not only represents Loving Angel Service Dogs, but also acts as an ambassador and a public educator on behalf of all service dogs. It is vital that the dog is well mannered and clean and neat when out in public. Do you think your child is physically and emotionally capable of doing all that is necessary to take care of a dog? If not, who will help with these tasks? _____

_____

Do you agree with the following?

That your Loving Angel Service Dog will spend most of their time *with* your child at home, and when you go out. (if a public access dog) They will NOT be alone in a yard or kennel for an extended period of time. Yes No

That your Loving Angel is not the family pet. This service dog has duties that he/she has been trained to do and should have minimal interaction with others. ☐ Yes ☐ No

You have a reasonable expectation that their medical situation will allow them to use their service dog for the next 8 to 10 years. ☐ Yes ☐ No

That you will keep the dog safe and will not allow them off leash except in a secure area. This includes during exercising and elimination. ☐ Yes ☐ No

Your family can assume full responsibility for your Loving Angel. This includes many areas:

Daily grooming including brushing coat and teeth. ☐ Yes ☐ No

Periodic baths and toenail trimming ☐ Yes ☐ No

Medical care as prescribed by your veterinarian ☐ Yes ☐ No

Proper feeding with a good quality dog food to maintain overall health, coat health and to maintain the dog's proper weight. ☐ Yes ☐ No

Daily exercise and playtime ☐ Yes ☐ No

You will assume full responsibility for cleaning up after the dog eliminates in public and for repairing any damage caused by your dog. ☐ Yes ☐ No

Please describe who will handle the following areas of dog care – and how:

Feeding _____

Grooming _____

Exercising _____

Toileting _____

Vet Care _____

Financial Costs - yearly approximate costs:about $2,000/year

_____

If your child is hospitalized _____

_____

Flea problems _____

Heartworm prevention _____

Family/friend involvement _____

_____

Access Issues _____

Dog behavior problems _____

_____

Attending our Training Program _____

_____

Our training program is physically and emotionally demanding. What specific difficulties might your child have with it? _____

_____

What modifications do you need to make to accommodate this training? _____

_____

What modifications must the training program make to accommodate your child's specific difficulties?_____

_____

How will you handle costs and time required to attend the class? _____

_____

_____

How will you limit your activities and others' access to your child's dog for the 30-day bonding time?

_____

_____

List the **names, addresses and phone numbers** of two people – not related to you who will provide letters of recommendation for your family. Have them send their letters to the Executive Director at the address listed below.

1. Personal (not related to you)

_____

_____

_____

2. Personal (not related to you)

_____

_____

_____

Signature _____ Date _____

All the information I have provided is true to the best of my knowledge, up-to-date and accurate

SEND YOUR COMPLETED APPLICATION ALONG WITH A $40 CHECK MADE OUT TO
LOVING ANGEL SERVICE DOGS, INC.
3734 SUGAR LEO RD.
ST. GEORGE, UT 84790

CHILD CLIENT APPLICATION AND MEDICAL HISTORY

LOVING ANGEL SERVICE DOGS, INC.

PLEASE PRINT CLEARLY

MEDICAL HISTORY FORM

PUT YOUR CHILD'S NAME ON EACH PAGE and sign the release below and give all four pages to your physician or therapist to complete. Ask them to return it directly to Loving Angel Service Dogs

RELEASE OF MEDICAL INFORMATION

This authorizes you to release information regarding my condition to Loving Angel Service Dogs, Inc. This information will be used to evaluate and assess my situation and is essential for Loving Angel to train a service dog to increase my independence. All information is confidential.

Name _____ Date of Birth _____

_____
Parent/Guardian Signature

To the Physician or Therapist:

We maintain confidentiality of our clients' records. The information you give here will not be shared with your patient unless you give express permission.

If you have any questions, please contact Loving Angel Service Dogs, Inc. at (435) 632-2482

Mail the completed form to:

Executive Director
Loving Angel Service Dogs, Inc.
3734 Sugar Leo Rd.
St. George, UT 84790

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

PAGE 1

PATIENT NAME _____ DATE _____

PRACTIONER'S NAME: _____ SPECIALTY _____

Address: _____

Phone: _____

Date of Last Exam: _____ Length of association with patient: _____

What is the primary diagnosis? _____

What other conditions does the patient have? _____

_____

Prognosis for duration of impairment(s): _____

_____

Prognosis for progression of impairment(s): _____

_____

Prognosis for lifespan: _____

_____

Medications taken on a regular basis: _____

_____

How severe is the patient's mobility impairment?

NONE		NEEDS ASSISTIVE DEVICE		NEEDS FULL-TIME CARE
1	2	3	4	5

How severe is the patient's visual impairment?

NONE(correctible w/ glasses		NEEDS ASSISTIVE DEVICE		BLIND
1	2	3	4	5

How severe is the patient's auditory impairment?

NONE		NEEDS ASSISTIVE DEVICE		DEAF
1	2	3	4	5

How severe is the patient's cognitive impairment?

NONE		NEEDS ASSISTIVE DEVICE		NEEDS FULL-TIME CARE
1	2	3	4	5

Do limitations affect patient's ability to control his/her own behavior?

NORMAL		MODERATE		POOR SELF CONTROL
1	2	3	4	5

How effective is the patient on handling and overcoming their limitations?

VERY COMPETENT		MODERATE		INEFFECTIVE
1	2	3	4	5

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MEDICAL HISTORY FORM

PAGE 2

PATIENT NAME _____

How reliable is the patient – on time for appointments, compliant with meds, etc?

VERY RELIABLE		MODERATE		UNRELIABLE
1	2	3	4	5

To what degree do limitations affect patient's ability to function in activities of daily living* (ADL)

NORMAL		MODERATE		TOTALLY NEEDS HELP
1	2	3	4	5

Activities of Daily Living (ADL) refers to the ability to meet personal care needs, such as eating, bathing, dressing, etc., as well as the ability to perform tasks necessary for independent living – to be compliant with therapy and meds, manage finances, maintain home, acquire outside services.

COGNITIVE AND MENTAL EVALUATION:

	Yes	**Minimal**	**No**
Able to exercise judgment and make decisions necessary for ADL	____	____	____
Able to sustain attention span	____	____	____
Manifests inappropriate behavior beyond his/her control	____	____	____
Able to control physical or motor movement sufficient to sustain ADL	____	____	____
Capable of perception and memory to the degree necessary to sustain ADL	____	____	____
Able to follow directions and learn to the degree necessary to Sustain ADL	____	____	____
Under medication which impairs functioning	____	____	____
Capable of decision about personal and others' needs and safety	____	____	____

Is incapacity due to or affected by patient's alcoholism or drug abuse? Yes No

If Yes:

Has patient ever been in a treatment facility Yes No

If yes, when and duration? _____

Has permanent damage resulted? Yes No

Has patient refused treatment or referral to a treatment center? Yes No

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

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PATIENT NAME _____

Our service dogs are highly trained to assist their partners with many tasks besides being a loyal companion who gives unconditional love. Some of the tasks they may be trained to do are:

Retrieve dropped articles
Push Lifeline or 911 button
Find help
Retrieve items from refrigerator
Turn lights off and on
Open and close doors
Provide bracing for transfers
Enhance balance when walking
Enhance balance when taking the stairs
Assist in pulling wheelchair
Carry items in mouth or backpack
Take items to another person
Help undressing – shoes, socks, sweaters, etc.
Find and retrieve items like keys, etc.

Are there any other tasks that a service dog could do that your patient would benefit from?

_____

_____

_____

Do you think your patient would benefit from a service dog? Yes No How? Or Why not?

_____

_____

_____

Can you recommend that this patient receive a Loving Angel Service Dog? Yes No

Why or why not? _____

_____

May we contact you with questions? Yes No

Best way to contact you _____

Any addition comments: _____

_____

_____

Signature of physician or therapist: _____ Date _____