Philly Equine Partners, LLC

NEW PARTICIPANT INFORMATION

Date: _____

Name: _____ Age: _____

(First) (Last)

Address: _____
(Street) (City) (State) (Zip Code)

Cell Phone: _____

E-mail Address: _____ Add to Email List? YES NO

Emergency Contact Person/s: _____ Relationship: _____

Emergency contact person/s Phone: _____ cell: _____

How did you hear about Philly Equine Partners? _____

Issues or goals that you are hoping equine-assisted learning/therapy will help you with:

1. _____
2. _____
3. _____

Physical conditions or allergies that require caution around horses?

_____
_____

In case of life-threatening emergency: Medications? Y/N List: _____

Participant/Guardian: My signature on this form indicates agreement that the above information is current and correct. In addition, my signature indicates my authorization for Philly Equine Partners to contact listed emergency contact person and/or 911 in the event of a medical emergency.

Participant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(participants under 18yo)