



ANIMALS AS NATURAL THERAPY

721 Van Wyck Road • Bellingham, WA • 98226
 Phone/FAX: 360-671-3509 • Web: www.animalsasnaturaltherapy.org

Participant's Medical History

This registration must be filled out, signed by parent or legal guardian and sent to ANT, Inc. prior to first visit.

Full Name:	Date of birth:	Age:	Gender:
Custodial parent or guardian:	Phone:		
Home address of parent/guardian:	Phone:		
Business address:	Phone:		
Name of physician:	Phone:		
Emergency contact (if I am not available, please contact):			
Address:	Phone:		

GENERAL QUESTIONS:

Complete information is needed to insure instructor awareness and sensitivity to your child's behavior and needs and will not be used to screen out students.

(Explain "yes" answers below)

	Yes	No
1. Any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had head injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
8. Chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
10. Back problems?	<input type="checkbox"/>	<input type="checkbox"/>
11. Joint problems (e.g, knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Orthodontic appliance or headgear being used?	<input type="checkbox"/>	<input type="checkbox"/>
13. Any skin problems (e.g, allergies, rash, hives)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
15. Asthmatic?	<input type="checkbox"/>	<input type="checkbox"/>
16. ADD/ADHD diagnosed?	<input type="checkbox"/>	<input type="checkbox"/>
17. Short or long term memory impairment?	<input type="checkbox"/>	<input type="checkbox"/>
18. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question.

Please provide date of last Tetanus
Any known allergies? Specify:
What is your child's reaction to bee stings?
Any medications that will be taken during visits or to be aware of in case of an emergency?
Any diet restrictions?
Is there any health reason to limit child's activities?
Is there any general health concern, not listed, that would be helpful for us to know?
What would you like most for your child to experience with Animals as Natural Therapy?

Signature of Parent or Legal guardian

Date

THE GOALS FOR THIS CLIENT: (with dates)

Participant Information (Voluntary)

- Participant Resides in:
- Farm
 - Town or Rural Non-farm (pop. 10,000 or less)
 - Town or City (pop. 10,000-50,000)
 - Suburb (pop. 50,000 or more)
 - City (pop. 50,000 or more)
- Racial/Ethnic Group:
- Caucasian
 - African American
 - American Indian/Alaskan
 - Hispanic
 - Asian/ Pacific Islander
 - Mixed
- School Grade:
- 1st 2nd 3rd 4th 5th 6th
 - 7th 8th 9th 10th 11th 12th