A N I M A L S A S N A T U R A L T H E R A P Y
721 Van Wyck Road • Bellingham, WA • 98226
Phone/Fax: 360-671-3509 • www.animalsasnaturaltherapy.org

Participant Registration

Name:	Date of Birth:	Age:	Weight: (for horsemanship)	Height:
Street Address:	City:			
State:	Zip Code:			
Primary Caretaker:	Phone:			
Relationship to participant:	Email address:			
Address/Phone if different from above				
School/Institution attending:				
Were you referred by a school counselor? Yes ☐ No ☐	Name:			
How did you hear about ANT?				

Liability Release:

_____(Participant's name) would like to participate in the Animals as Natural Therapy programs. I acknowledge the risks and potential for risks of horse and farm activities. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Windy Acres and Animals as Natural Therapy, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Animals as Natural Therapy programming. I understand that these programs may include therapeutic counseling.

Date: _____ Signature:_____
Participant, Parent or Guardian

Photo Release (OPTIONAL):

I hereby consent to and authorize the use and reproduction by Animals as Natural Therapy of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: _____ Signature:_____
Participant, Parent or Guardia

2018

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Participant's Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Animals as Natural Therapy to secure and retain medical treatment and transportation if needed.

Full Name:	Date of birth:	Age	Gender:
Primary Caretaker:	Relationship:		Phone:
Emergency Contact:	Phone:		
Emergency Contact:	Phone:		
Name of physician:	Phone:		
Health Insurance Co:	Policy #:		
Preferred Medical Facility:			

Consent Plan
This authorization includes x-ray, surgery, hospitalization, and medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date:	Consent Signature:	Phone:
Print Name:	Relationship to Participant:	

Non-Consent Plan
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event of emergency treatment/aid is required, I wish the following procedures to take place:

Date:	Non-Consent Signature:	Phone:
Print Name:	Relationship to Participant:	

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Participant's Medical History

This registration must be completed, signed by legal guardian and sent to ANT prior to first visit.

Full Name:	Date of birth:	Age:	Gender:
Form completed by:		Relationship:	Phone:
What goals do you have for your child's time at ANT? ***required to participate***			
Any known allergies:		Date of last tetanus:	
What is your child's reaction to bee stings?			
Any medications that the youth will be taking during visits or to be aware of in case of an emergency?			
Any health reasons to limit child's activities/ at farm?			
Any diet restrictions?			

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?	☐	☐
2. Chronic recurring illness/condition?	☐	☐
3. Frequent headaches?	☐	☐
4. Ever had head injury?	☐	☐
5. Wear glasses, contacts, or protective eyewear?	☐	☐
6. Use mobility devices (cane, crutches, wheelchairs) or hearing aids?	☐	☐
7. Ever passed out during or after exercise?	☐	☐
8. Ever had seizures?	☐	☐
9. Chest pain during or after exercise?	☐	☐
10. High blood pressure?	☐	☐
11. Back problems?	☐	☐
12. Joint problems (e.g., knees, ankles)?	☐	☐
13. Orthodontic appliance or headgear being used?	☐	☐
14. Any skin problems (e.g., allergies, rash, hives)?	☐	☐
15. Diabetic?	☐	☐

16. Asthmatic?		☐	☐	
17. ADD/ADHD diagnosed?	Yes	☐	☐	No
18. Short or long term memory impairment?		☐	☐	
19. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals?		☐	☐	
20. Tendencies toward emotional/physical isolation?		☐	☐	

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

_____

_____

_____

Participant Information/Demographics

Funding from various grantors help ANT provide these experiences. Those grantors ask ANT to track this confidential information below. Thank you for assisting out reporting process.

Participant Resides in:

☐ Reservation ☐ 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)

Participant lives with: ☐ 1 Parent ☐ Both Parents ☐ Blended family
☐ Alternates between 2 parents
☐ Relative Placement
☐ Foster Family
☐ Adoptive Family
☐ Other _____

Racial/Ethnic Group: ☐ Caucasian
☐ African American
☐ Native American/Alaskan
☐ Hispanic/Latino
☐ Asian/ Pacific Islander
☐ Other:

School Grade: ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th
☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ not attending

Has the participant ever resided with anyone other than his/her birth family? Yes ☐ No ☐

Is the participant struggling academically? Yes ☐ No ☐

Is the participant struggling behaviorally or emotionally in school or social situations? Yes ☐ No ☐

Is the participant struggling behaviorally or emotionally at home? Yes ☐ No ☐

Has the participant or a close family member ever been incarcerated? Yes ☐ No ☐

Has the participant witnessed or experienced domestic violence? Yes ☐ No ☐

Has the participant or a close family member had any problems with alcohol or drugs? Yes ☐ No ☐

Is a close family member active in the military or a veteran? Yes ☐ No ☐

Does the participant identify as LGBTQ? Yes ☐ No ☐

To the best of my knowledge, the above is up to date and accurate.

_____ _____

Signature Date

ANIMALS AS NATURAL THERAPY

Participant Financial Responsibility Agreement

Thank you for allowing Animals as Natural Therapy to assist your child/ward in his/her experiential education. In the interest of good care practices, it is desirable to establish a credit policy to avoid misunderstanding. Our primary responsibility is to help our participants have successful sessions and we wish to spend our time and energy toward that end.

Charges are $75 per session. This is $675 per 9-week quarter, with one-third payment due on the first day ($250.00), the second third due on the fourth week, and the final third due by the seventh week of the quarter. Limited scholarships are available based on a sliding fee scale. To apply, please contact our program coordinator or office manager. Financial Assistance Forms must be submitted at least three weeks before the beginning of the quarter in order to have time to process and approve requests. approved. Proof of income is required.

Monthly statements will be sent to reflect the total amount due for the quarter less and payments or credits made. This statement will also show any financial assistance granted. Final payments are due by the end of the quarter.

Absence Policy:

- Volunteer mentors commit their time to work with each individual participant to ensure a safe and successful session.
- Please notify us 24 hours in advance if your child/ward will be absent. If it is a last minute emergency, we ask to be notified as soon as possible.
- We understand that emergencies do arise; however, an "instructor fee," equal to half the normal session fee, will be charged for last minute cancellations or if no notice is given.
- If a rider misses three (3) sessions without notification, future sessions will be cancelled for the quarter and no further financial assistance will be given.

I have read this credit policy and understand that I am responsible for payment of this account.

Participant Name _____

Organization providing funding: _____ Amount granted: _____

Contact person name: _____ Phone: _____ Email: _____

Other funding source: _____ Amount granted: _____

Contact person name: _____ Phone: _____ Email: _____

Family agrees to pay: _____

ANT Scholarship/Financial Assistance awarded: _____

Name of responsible party _____

Signature of responsible party _____ Date _____

Responsible party must be Parent or Guardian if participant is under 18 years old.