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?				

Summer Day Camp only:
Which session (circle one) 1 2 3 4 5 6 do you want your child to attend? See brochure for dates. T-shirt size _____youth _____ adult

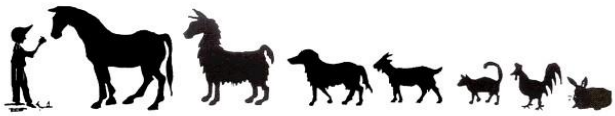
Liability Release:

_____(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



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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:
- ☐ Farm
- ☐ Reservation
- ☐ 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 of Parent or Legal guardian Date