CARLISLE ACADEMY
INTEGRATIVE EQUINE
THERAPY & SPORTS

PARTICIPANT INFORMATION

Student Name: _____ **DOB:** _____

Student Address:_____

Phone: _____ **Height** _____ **Weight**_____

Guardian Name/Relationship to Student:_____

Email address: _____ **Phone:**_____

Guardian Address:_____

Facility/ Group home/Case Manager (if applicable) _____

Phone: _____ **Address:** _____

Diagnosis (If applicable)**:**_____

Medical history/surgeries (if applicable)**:** _____

Are you a veteran? Yes No (circle one) Branch of Military: _____

What are your goals?_____

_____

Photo/Video Release

I (circle one) **DO** **DO NOT** consent to and authorize the use and reproduction by Carlisle Academy Integrative Therapy & Sports any and all photographs and any other audio/visual materials taken of (student) _____ for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Student/Legal Guardian: _____ Date: _____

Permission to Share Information with Lesson Volunteers

I (circle one) **DO** **DO NOT** Give permission to Carlisle Academy instructors to share information they deem appropriate regarding my son/daughter/ward and his/her disability/lesson goals/communication style, including any specific needs or precautions, with the lesson volunteers.

Student/Legal Guardian: _____ Date: _____