Equine Immersion Program

Registration Form

Veteran Name:

Date of Birth: Age: ☐ Male ☐ Female

Street Address:

Town: State: Zip Code:

Phone:

Email:

Wounded Warrior Reg. #

Branch of Service:

Deployment Location(s):

Deployment Dates:

Medical Condition(s):

Medication(s)/Dose:

Allergies: Epipen: Yes No

Dietary Issues:

Height: Weight:

*The Professional Association of Therapeutic Horsemanship Int'l (www.pathintl.org) has a 250lb weight limit for riding.

Do you request/require any special accommodations? ☐No ☐Yes

(Meals/Physical/Psychological)

Is there anything you want us to know so we can provide you with a safe and enjoyable experience?

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Emergency Medical Authorization for Treatment

Please provide the following information so EIP can provide support as needed:

Emergency Contact:

Name: **Relationship:**

Phone(s):

Address:

Primary Care Doctor:

Phone:

Medical Insurance Carrier:

Policy #: **Member #:**

If emergency medical aid or treatment is required due to illness or injury during the process of receiving services with EIP, I authorize EIP to:

1. **Perform, Secure and retain medical treatment and transport, if needed.**
2. **Release participant record upon request or to authorized emergency personnel/ healthcare provider involved in the emergency medical treatment.**

If emergency medical care is required and I am not able to convey permission in a timely manner, then I authorize the appropriate EIP and emergency medical personnel, a physician or the medical facility to provide treatment.

Signature: **Date:**