FOR OFFICE USE ONLY-ID
Date Received: _____
App. Number: _____

SPUR / MONMOUTH COUNTY PARK SYSTEM

805 Newman Springs Road, Lincroft, NJ 07738-1695
(732) 224-1367

APPLICATION UPDATE - FOR RETURNING STUDENTS

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (day) _____ (evening) _____

Parent/Guardian Name: _____

Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Disability: _____

Applicant's Physician: _____ Phone: _____

Applicant's Therapist: _____ Phone: _____

(O.T., P.T., other): _____ Phone: _____

Name of school or day program (if appropriate): _____

Please use the space below to inform us of any changes that have taken place since you last completed a full application. Include updates regarding; applicant's abilities, medications, behavior issues and/or behavior plans currently being implemented, general health, and any medical treatments or procedures that have taken place in the last year. Please include any information that will assist us in understanding and instructing the applicant. Do not leave this space blank. Use the back of this form for additional space.

_____

_____

_____

_____

_____

_____

Monmouth County Board of Recreation Commissioners
(Monmouth County Park System)
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 the Monmouth County Park System to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone: _____

Contact: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Company: _____Policy #: _____

ALLERGIES/MEDICAL CONDITIONS/MEDICATIONS

_____

CONSENT PLAN

I do 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. This provision will only be invoked if the person listed below is unable to be reached.

Date: _____ Consent Signature: _____
Participant, Parent/Legal Guardian

_____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM

Print Name: _____ Phone: _____

Address: _____

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 emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date: _____ Non-Consent Signature: _____
Participant, Parent/Legal Guardian

_____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIANS MUST SIGN THIS FORM

Print Name: _____ Phone: _____

Address: _____

MONMOUTH COUNTY BOARD OF RECREATION COMMISSIONERS
(MONMOUTH COUNTY PARK SYSTEM)
RELEASE FORM

LIABILITY RELEASE:

_____ (Participant's Name) would like to participate in the therapeutic horseback-riding program of the Monmouth County Board of Recreation Commissioners. I acknowledge the risks and potential for risks of horseback-riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby for myself and for _____ (Participant's Name), intending to be legally bound, for ourselves and our heirs and assigns, executors or administrators, waive and release forever all claims for damages against the County of Monmouth, the Monmouth County Board of Recreation Commissioners, its Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in this horseback-riding program.

Date: _____ Signature: _____
Participant or Parent/Legal Guardian

Signature: _____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM

PHOTO RELEASE:

_____ I do not wish to have my child photographed. (No signature required if this option is checked.)

_____ I hereby consent to and authorize the use and reproduction by the Monmouth County Park System of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: _____ Signature: _____
Participant or Parent/Legal Guardian

Signature:_____
Parent/Legal Guardian

BOTH PARENTS OR LEGAL GUARDIAN MUST SIGN THIS FORM

Would you be interested in having your child *featured* in a S.P.U.R. newsletter or other periodicals?

Yes _____ No ____

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type:_____ Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precaution/Needs: _____
_____
Mobility: Independent Ambulation YN Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -
Neurologic Symptoms of Atlantoaxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Cognitive			
Circulatory			
Emotional/Psychological			
Immunity			
Integumentary/Skin			
Learning Disability			
Neurologic			
Muscular			
Orthopedic			
Pain			
Pulmonary			
Speech			
Tactile Sensation			
Visual			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License /UPIN Number: _____