True Friends-True Strides
10509 108th St. NW
Annandale, MN 55302
952-852-0101 - Fax 952-852-0123
Email: info@truestrides.org
Website:www.truefriends.org

FOR OFFICE USE ONLY: Application Rec'd._____
Deposit Rec'd._____ _____
By_____
_____ *WC SLW 1 2 3 4 5 6 7 8*
P H SO Fb S D G O R C B RS H M L

Application must be filled in completely.
Please do not hesitate to include additional information which you feel may be helpful in the care of this individual. Thank you!

Rider Personal Information:

Name: _____
Last Legal First Name (Nickname) Middle Initial

Address _____
Street City State Zip

Telephone: _____

Email: _____

Age: _____ Date of Birth: _____ Male ☐ Female☐ Weight: _____

Contact Information:

Check type of living situation: Residential Facility ☐ Private Home ☐ Other ☐ Please list _____

If applicant lives outside of private home, what is the staff/client ratio? 1:1☐ 1:2☐ 1:3☐ 1:4☐ 1:5 or more ☐

Legal Guardian name

Legal name: _____ Relationship to applicant: _____

Cell phone: _____ Home Phone: _____ Work: _____

Email: _____

Guardian address: _____
Street City State Zip

Social Worker name:

Name: _____ Relationship to applicant: _____

Cell phone: _____ Home Phone: _____ Work: _____

Email: _____

Guardian address: _____
Street City State Zip

Confirmation of service should be mailed to: (check one) parent☐ guardian☐ facility☐ participant☐ other: _____

Applicant Name: _____ Date of Birth: _____

Contact Information Continued From Previous Page:

Emergency Contact Information #1:

Legal name: _____ Relationship to applicant: _____

Cell phone: _____ Home Phone: _____ Work: _____

Email: _____

Guardian address: _____

Street City State Zip

Emergency Contact Information #2:

Legal name: _____ Relationship to applicant: _____

Cell phone: _____ Home Phone: _____ Work: _____

Email: _____

Guardian address: _____

Street City State Zip

RELEASE SIGNATURES:

Attendance Release: I hereby give my permission for the applicant named above, to participate in True Friends (TF) sponsored and supervised programs**. I certify that the information on the application is true, accurate and complete.** TF emphasizes safety first; however participation in TF programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless TF, its employees, and agents.

Emergency Release: I hereby give permission to the non-medical staff selected by TF to provide routine health care, administer prescribed and comfort/first aid medications, and if needed, seek emergency medical treatment including x-rays, routine tests and treatment for applicant named above**. In the event that I cannot be reached in an emergency,** I hereby give permission to the physician selected by TF to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the applicant named above. I give permission to obtain copies of treatment and health records from any provider and I agree to release information and records necessary for treatment. TF cannot assume responsibility for any medical expenses that may occur if medical care must be sought.

_____

(REQUIRED) Signature of parent, legal guardian, applicant if own guardian, or authorized person Date signed

☐ **We are unable to obtain signatures at this time. A copy** of this section has been sent to the appropriate individual for signatures and will be mailed to True Friends one month prior to applicant's arrival.

Applicant Name: _____ Date of Birth:_____

Name of Person Completing Application: _____Date Application completed: _____

DISABILITY/OTHER CONDITIONS: Check one: ☐ with disability/other condition ☐ without disability/other condition
Please check all boxes that apply. Conditions in bold print * require an additional questionnaire which our office will send you.

☐Supervision or Support need is: ☐High ☐Medium ☐Low ☐Allergies to _____

☐Asperger Syndrome
☐Autism, type:_____
☐Attention Deficit Disorder or _____ Attention Deficit Hyperactivity Disorder
☐Alzheimer's or other Dementia (Beginning stages)
☐Blind/Vision impaired: _____Wears glasses _____Uses cane
☐Cerebral Palsy
☐Deaf/hearing impaired: _____wears hearing aid(s)

☐Uses sign language (needs a staff proficient in sign language)
☐Developmental/Cognitive or Intellectual Disability

☐Down Syndrome
☐Oppositional Defiant Disorder

☐Pervasive Developmental Disorder
☐ Prader-Willi Syndrome
☐Rett Syndrome
☐Tourette Syndrome
☐Traumatic Brain Injury
☐Williams Syndrome

☐Further explanation for any condition or other disorder, explain:
_____

Reaction: Hives ☐ Difficult breathing ☐
Anaphylaxis ☐Other _____

☐Arthritis
☐Asthma
☐*__Catheter:__ ☐intermittent ☐in-dwelling
☐colostomy or ileo appliances

☐*__Diabetes__, _____
☐__insulin dependent__

☐__*Feeding Tube:__ _____
☐*__Epilepsy/Seizures__, type & frequency:
_____

☐*__Orthopedic appliances__
☐splints ☐ braces ☐ prosthesis
☐ *__Respiratory:__ _☐ C-pap or ☐ bi-pap
☐nebulizer ☐ oxygen ☐suction
☐*__Tracheotomy__

☐other _____

☐Heart problems, explain: _____

Special Appliances/Ambulation – PLEASE PROVIDE NEEDED EQUIPMENT
Wheelchair? ☐Yes ☐No ☐long distances only ☐Manual ☐Electric ☐Stroller
Slow Walker? ☐Yes ☐No
Assistance in walking? ☐Yes ☐No ☐support from another person ☐cane ☐walker ☐crutches
Assistance in transferring? ☐Yes ☐No
What type of transfer is used?_____Mechanical Lift Only: ☐Yes ☐ No
Require **range of motion** exercises? ☐Yes ☐No If yes, please attach a copy of exercises.
Does applicant wear/use? ☐Orthotics-------- ☐left ☐right ☐Prosthesis----- ☐left ☐right ☐Braces/night braces
Further Instructions:
_____

Bathroom Use
Assistance in bathroom? ☐Independent ☐Needs reminders ☐Needs assistance ☐Total assistance
Use of incontinent product? ☐Yes ☐No
Further Instructions: _____

Communication
Able to communicate wants/needs? ☐Yes ☐No
☐Verbal ☐Uses a communication device ☐Sign Language ☐Non-verbally/gestures
Type of communication devise: _____
Understand/respond to questions? ☐Yes ☐No Needs extra time to process information ☐Yes ☐No
Has difficulty understanding the communication of others ☐Yes ☐No
Has difficulty expressing thoughts ☐ Yes ☐No
Able to read? ☐Yes ☐No Able to write? ☐Yes ☐No Can individual communicate pain? ☐Yes ☐No
Further Instructions: _____

Applicant Name: _____ Date of Birth: _____

Challenging Behavior - Check that apply: (provide as much information as possible – use another paper as needed)

☐Verbally challenging ☐Temper tantrums ☐Stubbornness ☐Wanders unintentionally due to distractions
☐Withdrawn/shy ☐Physically challenging toward objects
☐Displays unusual behaviors
toward male staff ☐Displays unusual behaviors toward female staff
☐Other, describe: _____
Ever been away from home before? ☐Yes ☐No
Do you anticipate any concerns with this applicant going into the community ☐ Yes ☐ No
If yes please explain (refusing to wear a seat belt, difficulties riding in a vehicle, difficulty waiting, wandering, inappropriate interaction with strangers, etc): _____

If any of the following apply you are required to explain prevention/intervention:
☐**Self-injurious*** ☐**Lies / Steals*** ☐ **Removes clothing at inappropriate times or locations**
☐**Physically challenging toward others*** ☐**Wanders or runs away intentionally*** ☐**Bites***
☐**Swears*** ☐**Has fears***
☐**Food-related behaviors*** (stealing, temper tantrums, eating inedible objects, manipulation)
Does this applicant ever require physical intervention? ☐ Yes ☐ No
Please explain what type of physical intervention is used, for what purpose and how frequently this type of intervention is used:
_____

If there is any physical intervention that is contraindicated medically? ☐Yes ☐No
Explain: _____

Prior True Friends Experience:
Has the applicant ever attended True Friends services? ☐Yes ☐No ☐No, but I'd like more information about:
☐ Respite ☐ Summer Resident/Day Camp ☐Winter Resident Camp ☐Adventure Trip ☐Weekend Focus

Check site(s) attended:
☐Camp Friendship ☐Camp Eden Wood ☐Camp New Hope ☐Camp Courage ☐Courage North
How did you hear about True Strides?
☐social worker ☐teacher ☐friend/family ☐Arc ☐DSAM ☐AUSM ☐other support organization:
☐internet search/which site: _____

Attends school? ☐Yes ☐No
Where: _____ Type of Class: _____
Employed? ☐Yes ☐No Where: _____
What do they do at their job? _____

Please list any additional information regarding applicant, which may be helpful to staff (likes/dislikes):
_____

Applicant Name: _____ Date of Birth: _____

Fee Agreement (4 lessons are $720) Hippotherapy
Fee Agreement (4 lessons $320) Therapeutic Riding

☐ I / We will pay cost of $ _____

☐ Fee will be paid by: _____
Amount Name of Payee address city state zip

☐ I will contribute $ _____ to the "Donor Fund" to help another person attend a True Friends program.

Method of Payment

☐ Cash

☐ Check (Check# _____)

Photos and Funds

Publicity Release: True Friends uses photographs, images or recordings of applicants for publication in brochures, email, website and various other media to promote services or to recruit volunteers and staff. The applicant named above **MAY be included** in these promotional materials unless you contact Registration.

Seeking Funds: True Friends uses riders name to seek funds from donors for Financial Assistance. This applicant's first name and last initial **WILL be included** in seeking funds unless you contact Registration.

I/We verify that the information on this application is true and accurate.

_____
Signature of rider/guardian Date