Name: Male: Female:
Address:
Date of Birth: Age:
What are the hopes/expectations for the above on completion of the programme?
Please describe reasons for referring the above. (e.g.) to develop self-esteem, concentration, communication skills. Please use this space for further comments.
Is the above individual on any medication? Yes No If yes please state which medication and for what reason.

Bruree, Co Limerick.
Tel: 086 1947323 **Web:** www.theponyway.com

Is the above allergic to anything (including horses)? Yes No If Yes please state what the allergy is.
Optional: Is the above living with family members or others? How would you describe their relationship with family members?
Name of parent/guardian or organisation phone no and contact person:
Action Taken:
Signed : **Date:**

For Office Use Only.

Date Received:
Signed: **Date:**