WILLOW CREEK RANCH, INC.

PATH INTERNATIONAL

Participant Registration

GENERAL INFORMATION

Print Clearly

Participant Name: _____

DOB: _____ Age: _____ Gender: M / F Height: _____ Weight: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____

School: _____ Grade: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone: _____

Employer: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Referral Source: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Current condition that may impact participation (e.g. mobility, communication skills, sensory issues) _____

_____

_____

Seizures: □ Yes □ No _____

Allergies: □ Yes □ No _____

Bee Stings: □ Yes □ No Epi-pen: □ Yes □ No

Asthma: □ Yes □ No _____

Photosensitivity: □ Yes □ No

MEDICATIONS: *(include prescription and over-the-counter)*

Name of Medication	Dose	Frequency

OTHER INFORMATION YOU WOULD LIKE TO SHARE (e.g. caregiver name, personal, health, social):

PARTICIPANT EXPECTATIONS/GOALS FROM RECEIVING SERVICES AT WCR:

Participant Signature _____ Date _____

Print Name _____

Parent or Legal Guardian Signature _____ Date _____