



High Lonesome Therapeutic Equestrian Center
15712 Joe Brown Hwy
Murphy, NC 28906

(828) 835-3739

highlonesomestables@gmail.com
www.highlonesomestables.org

Participant Registration Form

Date: _____

Participant's Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ Home Phone: _____

E-mail: _____ Cell Phone: _____

Participant's School/Employer (if applicable): _____

Mother's Name: _____ Home Phone (if different from above): _____

E-Mail: _____ Cell Phone: _____

Mother's Address (if different from above): _____

Employed by: _____ Phone: _____

Father's Name: _____ Home Phone (if different from above): _____

E-Mail: _____ Cell Phone: _____

Father's Address (if different from above): _____

Employed by: _____ Phone: _____

Spouse's / Guardian's Name: _____ Cell Phone: _____

E-Mail: _____ Employed By: _____

Give a brief explanation of the disability: _____

Indicate any medical devices (shunt, feeding tube, port-a-cath, insulin pump, etc.) and their location: _____

Spinal Joint Fusion/Fixation: Yes No If yes: Date: _____ Location: _____

List any therapies currently receiving and name of the therapist(s): _____

Participant Name _____

IN CASE OF AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

FORM REVIEWED (Please Initial): 2022: _____ 2023: _____ 2024: _____ 2025: _____ 2026: _____

ADULT PARTICIPANT/PARENT/GUARDIAN MUST INITIAL ONCE PER YEAR TO VERIFY INFORMATION IS CURRENT. MAKE ANY CHANGES PRIOR TO INITIALING. NEW FORMS AVAILABLE UPON REQUEST.