

**MEDICATIONS** (include prescription, over-the-counter; name, dose and frequency) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):*  
**PHYSICAL FUNCTION** (i.e., Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PSYCHO/SOCIAL FUNCTION** (i.e., Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GOALS** (i.e., Why are you applying for participation? What would you like to accomplish?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Client, Parent or Legal Guardian (signed in the presence of center staff)

**PHOTO RELEASE**

- I  DO  
 DO NOT

consent to and authorize the use and reproduction by GAITS OF FREEDOM of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Client, Parent or Legal Guardian (signed in the presence of center staff)