LittleOASIS
EQUINE MATTERS

REFERRAL FORM

PARTICIPANTS NAME: _____DOB:_____

PARENT(S) NAMES: _____

ADDRESS: _____

CITY: _____PROV: _____POSTAL CODE: _____

TELEPHONE: _____EMAIL:_____

ALLERGIES/HEALTH CONCERNS:

_____

_____

☐ **Funding is required (group only)**

FUNDER/SPONSOR NAME: _____

MAILING ADDRESS: _____

CITY: _____PROV: _____POSTAL CODE: _____

TELEPHONE: _____EMAIL:_____

PROGRAMS AVAILABLE:

☐ Private Equine-Assisted Learning Program
☐ Group Equine-Assisted Learning Program

REGISTRATION INFORMATION:

Please forward registration application to: littleoasisequine@gmail.com

Absences are not reimbursed.

Authorized signature / Position:

_____