Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: Result: + —

Neurologic Symptoms of AtlantoAxial Instability:

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ License/UPIN Number: _____

Signature: _____ Date: _____

SPIRITHORSE THERAPEUTIC RIDING CENTER

Contraindications and Physician's Medical Release

Date: _____

Dear Physician:

Your patient,_____, is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification / Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability / Abnormalities

NEUROLOGIC

Hydrocephalus/Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

OTHER

Indwelling Catheters
Medications - i.e. photosensitivity
Skin Breakdown

MEDICAL/PSHCHOLOGOCAL

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address/phone indicated below.

Sincerely, SpiritHorse Therapeutic Riding Center

Client's Name: _____ Phone:_____

Physician's Signature: _____ Date: _____

SPIRITHORSE THERAPEUTIC RIDING CENTER

Authorization for Emergency Medical Treatment Form

[ ] Participant [ ] Visitor [ ] Volunteer

Name: _____ DOB: _____ Phone: _____
Address: _____

Physician's Name: _____
E-MAIL Address: _____
Medical Facility: _____
Health Insurance Company: _____ Policy #: _____
Allergies to medications: _____
Current medications: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid / treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize SpiritHorse Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan
This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.
Date: _____ Consent Signature: _____

Client, Parent, or Legal Guardian

Non-Consent Plan
I do not give my consent for emergency medical treatment! aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/ aid is required, I wish the following procedures to take place:

_____
_____
_____

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

SPIRITHORSE THERAPEUTIC RIDING CENTER
Release of Liability

This Release of Liability is made and entered into on this date_____and for thereafter between Patricia Gayle Thorn (Executive Director), SpiritHorse Therapeutic Riding Center, and _____(The Participant); and, if Participant is a minor, their Parent or Legal Guardian (father)_____(mother)_____

In return for the use, today and on future dates, of the property, facility and services of the Executive Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. Participant agrees to assume any and all risks involved in or arising from participant's use of or presence upon Executive Director's property and facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
2. Participant agrees to hold Executive Director and all it's successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon Executive Director's property and facility, including without limitation, those based on death, bodily injury, property damage, including consequential damages, except if the damages are caused by the direct, willful and wanton negligence of the Executive Director.
3. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/ or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.
4. Participant agrees to indemnify and defend Executive Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon the Executive Director's property or facility.
5. Participant agrees to abide by all of the Executive Director's safety rules and regulations.
6. This contract is non-assignable and non-transferable, and is made and entered into in the State of Alabama, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When the Executive Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.

WARNING: Under Alabama law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to the Equine Activities Liability Protection Act.

Parent Father _____ Date _____

Parent Mother _____ Date _____

Photo release- please check one:

□ I consent to and authorize the use and reproduction of any and all photographs and any other audio-visual materials taken of me or my child for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

□ I do not consent to the use and reproduction of photographs and other audio-visual materials taken of me or my child for any purpose.

Parent signature _____

Name of Current School:

_____

APPLICANT HEALTH HISTORY

Current Medications of Applicant (over-the counter included):

Please describe applicant's <u>FUNCTIONAL</u> abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

_____

_____

Please describe applicant's <u>SOCIAL</u> abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

Any Allergies specific to being outside in nature:

_____

APPLICANT INFORMATION

Goals (reason for applying; what would you like to see accomplished):

_____

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings) (Dislikes: pets, sounds, etc.):

_____

What types of things work best for the applicant in terms of rewards and motivation?

How does the applicant best communicate with others?

- ☐ Spoken Language
- ☐ Sign Language ☐ASL ☐E/E
- ☐ Written Language
- ☐ Communication device
- ☐ Combination of the above (please describe)

Does the applicant use:

- ☐ Echolalia (repeating words without regard for meaning)
- ☐ Stemming (rocking, spinning, hand flapping)
- ☐ Self Regulatory Behavior (Please describe how the applicant uses this self soothing behavior):

Do changes in the applicant's environment affect their behavior?

☐ Never ☐ Sometimes ☐ Frequently

Please return to: SpiritHorse TRC
1962 Suncrest Drive
Prattville, Al 36067

Or Email to: spirithorsetrc@yahoo.com