

SPIRITHORSE THERAPEUTIC RIDING CENTER
Client Information Form

Name _____ Age _____ DOB _____

Any allergies related to being outdoors in nature? _____

Describe any weakness physically _____

Describe any cognitive delay _____

Describe emotional challenges _____

Please describe the applicant's FUNCTIONAL difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

Please describe the applicant's SOCIAL abilities and difficulties:

Grade completed _____ Challenges in school _____

Favorite leisure interests _____

Companion animals _____

Fears and concerns _____

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

Please tell us about the applicant.

(Likes) _____ (Dislikes) _____

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

How does the applicant communicate most effectively with others?

Does the applicant use:

Echolalia (repeating words without understanding their meaning) _____

Stimming (rocking, spinning, hand-flapping) _____

Self-regulating behaviors _____

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

If so, please describe: _____

Please email or bring this form to the address below. Thank you.

SpiritHorse Therapeutic Riding Center, 812 County Road 49, Marbury, AL 36051
Phone # 334-531-7019 Email: alabamaspirithorse@gmail.com

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: _____

THORSE THERAPEUTIC RIDING CENTER
Contraindications and Physician's Medical Release

Date: _____

Dear Physician:

Your patient, _____, is interested in participating in supervised equestrian activities. 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/PSYCHOLOGICAL

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, 812 County Road 49, Marbury, AL 36051
Phone # 334-531-7019 Email: alabamaspirithorse@gmail.com

SPIRITHORSE THERAPEUTIC RIDING CENTER

Authorization for Emergency Medical Treatment Form

() Participant () Visitor () Volunteer

Name: _____

DOB: _____ Phone: _____

Address: _____

E-MAIL Address: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

In the event of an 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 "lifesaving" by the physician. This provision will only be invoked if the person(s) above are unable to be reached.

Date: _____ Consent Signature: _____

Client, Parent, or Legal Guardian

Photo release- please check one:

- I consent to and authorize the use and reproduction of any 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 Father _____ Date _____

Parent Mother _____ Date _____

Release of Liability

This Release of Liability is made and entered into on this date _____ and for thereafter between 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 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 its 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 direct, willful and wanton negligence of the Executive Director causes the damages.
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 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. Failure to comply with these rules may result in immediate termination of the activity and could lead to serious injury or death.
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 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, ensuring a committed and bound relationship.

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.

By signing this page, you are stating you have read and understand and agree to a release of liability.

Parent Father _____ Date _____

Parent Mother _____ Date _____

Executive Director Gayle Thorn _____ Date _____