Enrollment Packet

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION

Participant: _____

DOB: _____Age: _____ Height: _____ Weight: _____ Gender: M F

Phone: _____ E-mail _____Alterative #: _____

Address: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

Referral Source: _____Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis Date of Onset: _____

Please indicate current or past special needs in the following areas:

	Yes	No
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		

Emotional/Mental Health _____

Behavioral _____

Pain _____

Bone/Joint _____

Muscular _____

Thinking/Cognition_____

MEDICATIONS *(include prescription, over-the-counter; name)* _____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)

PHYSICAL FUNCTION (Le. Mobility skills such as transfers, walking, wheelchair use, driving, bus riding) _____

_____

PSYCHO/SOCIAL FUNCTION (Le. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animal, fears/concerns) _____

_____

_____

What are your GOALS? What would you like to accomplish with therapeutic horseback riding? _____

_____

_____

PHOTO RELEASE

I DO _____

I DO NOT _____

Consent to and authorize the use and reproduction by 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: _____

RIDER'S APPLICATION

TO BE COMPLETED BY PARENT, CAREGIVER OR THERAPIST
PLEASE INCLUDE ANY OTHER INFORMATION WHICH WOULD BE HELPFUL.
USE THE BACK OF THIS FORM OR ADDITIONAL SHEETS IF NEEDED.

Rider's Name: _____

Long term goals: _____

_____

Short term goals: _____

_____

Specific activities/ exercises being used to achieve these goals: _____

_____

Behaviors to be encouraged: _____

_____

Behaviors to be discouraged: _____

_____

Rider's likes, dislikes, interests, hobbies: _____

_____

What is the rider's major challenge? _____

_____

Behavior patterns which may affect our work with this rider: _____

_____

What is the most effective method used in communicating with this rider? _____

_____

Guardian Name: _____

Telephone _____E-Mail _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

Name: _____DOB: _____ Phone: _____

Address: _____

Physician's Name: Preferred Medical Facility: _____

Health Insurance Company: _____

Policy: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact: _____

Name: Relation: Phone: _____

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 Hearts staff or volunteers 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)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORYSHOULD BE ATIACHED TO THIS FORM

PARTICIPANT'S MEDICAL HISTORY & PHYSICAN'S STATEMENT

This should be completed by your doctor or therapist.

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

Address: _____

Seizure Disorder/Type? _____Controlled: Y N Date of Last Seizure: _____

Diagnosis: _____Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

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**:* Atlantoaxial Interval X-rays, date: _____Result: _____

Neurologic Symptoms of Atlantoaxial Instability: _____

Please indicate current or past special needs in the following systems/area: _____

To my knowledge, there is no reason why this person cannot participate in supervised therapeutic horseback riding. However, I understand that Hearts 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 in the implementation of an effective equine activity program.

(e.g. PT, Of, SLP, Psychologist, etc.)

Name/Title: MD_____ DO_____ NP_____ PA_____ Other _____

Date: _____

License/UPIN Number: _____

Signature: _____

Address: _____

Signature: _____

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

1 hereby authorize: the staff of Hearts Therapeutic Riding to release information from the records of:

_____

(participant's name)

The information is to be released to: _____

(center or therapist's name)

For the purpose of developing an equine activity program for the above-named participant. The information to be released is indicated below:

___ Medical History

___ Physical Therapy evaluation, assessment and program plan

___ Occupational Therapy evaluation, assessment and program plan

___ Mental Health diagnosis and treatment plan

___ Individual Habilitation Plan CI.H.P.J

___ Classroom Individual Education Plan CI.E.P

___ Psychosocial evaluation, assessment and program plan

___ Cognitive-Behavioral Management Plan

___ Other: _____

Signature: _____ Date: _____

Printed Name

EQUINE WAIVER & RELEASE FORM

This Waiver and Release from tort and civil liability is made this _____ day of_____(mo.), _____(yr.), between Equine Activity Participant _____ (Participant) and Hearts Therapeutic Riding.

1. Participant understands that there are risks inherent in dealing with horses and ponies (equine activity). For example, Participant understands that some of the inherent risks include:
    a. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
    b. The unpredictability of an equine's reaction to sounds, sudden movements, unfamiliar objects, persons, or other animals;
    c. That there may be hazards, including, but not limited to, surface or subsurface conditions;
    d. The possibility of a collision with another equine, another animal, a person, or an object;
    e. The potential of an equine activity Participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the Participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the Participant;
2. With full understanding of the inherent risks involved in equine activity, some of which have been described in Paragraph 1 above, Participant agrees to wave, release and hold harmless HTR from all tort and civil liability arising from or related to participation in equine activity. This agreement to waive, release and hold harmless includes not only HTR but their employees, volunteers, agents, and independent contractors whether they be trainers, veterinary personnel, farrier's equine care providers, and maintenance personnel and the like.
3. Participant further understands the examples of the equine activity taking place on or with an equine, including, but not limited to:
    a. Riding, jumping, showing, competitions, fairs, trade shows, trail riding, and the like;
    b. Teaching, instructing, and evaluation, both the rider and the equine;
    c. Routine care and feeding of the equine (Boarding), including veterinary and farrier;
    d. Traveling, loading and unloading of equines;
    e. Breeding activity, both natural and artificial.
4. This Voluntary Waiver Agreement is made and entered into in the State of Texas and shall be enforced and interpreted under the courts and laws of the State of Texas.

"WARNING"

"Under Texas law (Chapter 87, civil practice and remedies code), an 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.

5. Participant agrees that Participant has been given sufficient time to read, understand, and ask questions, if any, concerning the nature and scope of this Voluntary Waiver Agreement.

Lisa Rivers _____ _____**Date:**_____

Stable / Farm Owner. **Participant**

or Author. Rep _____**Date:**_____

For: Hearts Therapeutic Riding **Parent or Guardian if Participant is a minor**