Participant's Application & Health History

GENERAL INFORMATION

Participant:_____
DOB:_____ Age:_____ Height:_____ Weight:_____Gender: M F
Address:_____
Phone:_____ Email:_____
Alternative Phone Number(s)_____
Employer/School:_____
Address:_____
Phone:_____
Parent/Legal Guardian:_____
Caregivers:_____
Address (if different from above):_____
Phone: _____
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:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency)_____
_____
_____
_____
_____
_____

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

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____
_____

PSYCHOSOCIAL FUNCTION (e.g., 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:_____

PHOTO RELEASE (Please circle one)

I DO
DO NOT

consent to and authorize the use and reproduction by Heads Up Special Riders, Inc. 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

Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)
to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: *Heads Up Special Riders, Inc.* for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below: (Please Circle)

- Medical history
- Physical therapy evaluation, assessment and program plan
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: _____

This release is valid for one year and can be revoked, in writing, at my request.
Signature: _____ Date: _____
Print Name: _____
Relation to Participant: _____

Please send materials to: Heads Up Special Riders
121 Laurel Ave
Kingston, NJ 08528

Date: _____
Dear Health Care Provider:
Your patient

_____
(participant's name)
is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation Fire Settings
Spinal Joint Instability/Abnormalities Hemophilia

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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

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: Neurologic Symptoms of Atlanto Axial Instability: Present Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities

	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and / or therapies. I understand that Heads Up Special Riders will weigh the medical information given against the existing precautions and contraindication. Therefore, I refer this person to Heads Up Special Riders for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other _____

Signature:_____

Date:_____

Address:_____

Phone:_____License/UPIN Number:_____