Dream Catcher of Los Angeles Therapeutic Riding Centers
Location Address: 1003 West Carson Street Long Beach, CA 90810
Phone: 310-350-1311 FAX: 310-823-7878 Email: JoanBlank@dreamcatcherLA.com
Mailing Address: PO Box 11993 Marina Del Rey, CA. 90295
www.dreamcatcherla.com

Participant's Application

Date_____

Participant Name: _____ Phone: _____

DOB_____Age_____Height_____Weight_____ Gender M F

Address_____

Tel. Home_____ Work/Cell_____

Email:_____

Employer/School_____

Address:_____Tel;_____

Name of Parent or Guardian:_____

Tel Home:_____Work:_____Cell:_____

Address (if different than above)_____

Referral Source:_____

How did you hear about the program:_____

I am a new rider ____Yes____No I am a returning rider ____Yes____No

I am a new rider and have previously ridden with another therapeutic center __Yes__No

If yes, how long_____

1003 West Carson Street Long Beach, CA 90810

Participant Liability Release, Confidentiality Agreement, Photo & Video Release

Participant Name: _____Date: _____

Parent/Legal Guardian/ Conservator (if applicable) _____

Liability Release:

Name of Parent/Guardian/Conservator_____

I acknowledge the risks and potential risks for horseback riding and activities in and around a facility where horses are kept and farm machinery operated. However, I feel that the possible benefits to me/my son/my daughter/my ward are greater than the risk assumed. Intending legally to bind myself, my heirs, and assigns, executors or administrators, I hereby waive and release forever all claims for loss or damages of any kind against Dream Catcher of L.A. Therapeutic Riding Centers, its' Board of Directors, Instructors, Therapists, aids, Volunteers and employees for any and all injuries and losses that I/my son/my daughter/my ward may sustain while participating in the Dream Catcher of L.A. Therapeutic Riding Centers program. This release includes without limitation the risk of negligent instruction and supervision. I engage in activities at Dream Catcher of L.A. Therapeutic Riding Centers voluntarily with knowledge of the risks and I assume all risks of injury, death, and property damage that may result. I agree to bear any loss myself. I acknowledge that Dream Catcher of L.A. Therapeutic Riding Centers and the property owners are materially relying on this waiver and assumption of risk in allowing me/my son/my daughter/my ward to participate in the Dream Catcher of L.A. Therapeutic Riding Centers activities on said property.

Date_____ Signature_____
(Participant, Parent or Caregiver)

Confidentiality Agreement:

I understand that all the information (written and verbal) about participants at this Professional Association of Therapeutic Horsemanship (PATH, International center) is confidential and not to be shared with anyone without expressed written consent of the participant and their parent/guardian in the case of a minor.

Date_____ Signature_____
(Participant, Parent or Caregiver)

Photo and Video Release:

_____ I consent to and authorize
_____ I do not consent

The use and reproduction by Dream Catcher of LA Therapeutic Riding Centers of any other audio/visual materials taken of me/my son/my daughter/my ward for distribution to the public for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date_____ Signature_____
(Participant, Parent or Caregiver)

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Authorization for Emergency Medical Treatment Form

Name_____DOB_____ Phone_____

Address_____

Physician'sName_____

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_____

Consent for Emergency Medical Treatment:

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 Dream Catcher of L.A. Therapeutic Riding Centers 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.

This authorization includes x-rays 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 for Emergency Medical Treatment:

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.
Parent or legal guardian will remain on site at all times during equine assisted activity
In the event emergency treatment/aid is required, I wish the following procedure to take place:_____

Date_____Non-Consent Signature_____
(Client, Parent or Legal Guardian)
Signed in Presence of center staff

1003 West Carson Street Long Beach, CA 90810

Participant's Health History

Name:_____ **Diagnosis:**_____

Please indicate current or past difficulties in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Speech or communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Allergies			
Thinking/Cognition			
Other			

Please list what medications are currently being taken, including over-the-counter medication:

_____

_____

Mobility Status (walks unassisted, assistant devices, etc):

_____

_____

_____

Goals (why are you applying for participation? What would you like to see accomplished?)

These categories are simply meant as guidelines and may not apply to all riders:

Riding Goals_____

_____

_____

Physical Goals_____

_____

_____

Cognitive Goals_____

_____

_____

Social Goals_____

_____

_____

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Information for Physician

(Please give to the rider's physician as a guideline for Therapeutic Riding)

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Please complete the Dream Catcher of Los Angeles Medical Release and Health History Assessment forms. Also, please note if any of the following conditions are present, and to what degree.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathological Fractures
Coxas Arthrosis
Heterotopic Ossification
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Medical/Surgical

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

Neurologic

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Secondary Concerns

Behavior Problems
Age under Two Years
Age Two - Four Years
Indwelling Catheter
Acute Exacerbation of Chronic Disorder

Physician's Statement

(Pages 6 & 7 are to be filled out completely by the Participant's Doctor)

Participant Name_____ DOB_____ Height_____Weight_____

Primary Diagnosis_____

Secondary Diagnosis: _____

Past/Prospective Surgeries: _____

Medications_____

Seizures Y N Type_____ Controlled Y N Date of Last Seizure_____

Shunts/Implants/Appliances _____

Special Precaution Needs_____

_____

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

Braces/Assistive Devices:_____

For those with Down Syndrome: AtlantoDens Internal X-Rays: Date_____ Result:_____

_____

Neurologic Symptoms of Atlanto Axial Instability:_____

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

Area	**Yes**	**No**	**Comments**
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurologic			
Bowel/Bladder			
Muscular			
Orthopedic			
Allergies			
Behavior			
Cognition			
Emotional/Psychological			
Tactile Sensation			
Immunity			
Balance			
Learning Disability			

Physician Release

ParticipantName:_____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However I understand that Dream Catcher of Los Angeles Therapeutic Riding Centers will weigh the medical information contained in the physician release form against existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional) e.g. PT, OT, Therapist, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Signature:_____ Date:_____

Physician's name, address and telephone number. (please print, type or stamp):

_____

_____

_____

_____

(***Pages 6 &*** *7 are to be filled out, dated and signed by the Participant's Physician and returned to the Program Director for Dream Catcher of Los Angeles Therapeutic Riding Centers prior to any participation in the program)*

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