

**Dream Catcher of Los Angeles Therapeutic Riding Centers**

Location Address: 1003 West Carson Street Long Beach, CA 90810

Phone: 310-350-1311 Email: Info@dreamcatcherla.com

Mailing Address: PO Box 41501, Long Beach, CA 90853

[**www.dreamcatcherla.com**](http://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



**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

###  Confidentiality Agreement:

Signature

(Client, Parent or Legal Guardian)

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

(Client, Parent or Legal Guardian

###  Photo and Video Release: (please check one)

 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 \_\_\_\_\_\_\_(Client, Parent or Legal Guardian)



### 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

### 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*



### Participant’s Health History

**Name: Diagnosis:**

*Please indicate current or past difficulties in the following areas:*

 **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 Medical/Surgical

Spinal Fusion Allergies

Spinal Instabilities/Abnormalities Cancer

Atlantoaxial Instabilities Poor Endurance

Scoliosis Recent Surgery

Kyphosis Diabetes

Lordosis Peripheral Vascular Disease Hip Subluxation and Dislocation Varicose Veins

Osteoporosis Hemophilia

Pathological Fractures Hypertension

Coxas Arthrosis Serious Heart Condition

Heterotopic Ossification Stroke (Cerebrovascular Cranial Deficits Accident)

Spinal Orthoses

Internal Spinal Stabilization Devices

**Neurologic Secondary Concerns**

Hydrocephalus/shunt Behavior Problems

Spina Bifida Age under Two Years

Tethered Cord Age Two - Four Years

Chiari II Malformation Indwelling Catheter

Hydromyelia Acute Exacerbation of Paralysis due to Spinal Cord Injury Chronic Disorder

Seizure Disorders

**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 AtlantoAxial 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**

Participant Name:

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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