21348 County Road 1495 Ada, OK 74820
www.leapofaithtrc.org
Office-(580)272-0498 Kathy's cell-(580)453-0009

Participant Interest Form

General information: Print Legibly

Name: ____

Address: ________________________________ City: __________________ Zip: __________

Phone: (Home) ___________________________ (Cell) ________________________________

Date of Birth: _________________ Height: __________ Weight: ___________ M ______ F ______

School: ____

Work: ____

Diagnosis: ____

____

Parent/Legal Guardian/Caregiver:

Please circle: Mother / Father / Guardian

Name: _________________________________ Email:________________________________

Address: ______________________________ City: ___________________ Zip: ____________

Phone: (H) ____________________ (W) ____________________ (Cell) ____________________

Please circle: Mother / Father / Guardian

Name: _________________________________ Email:________________________________

Address: ______________________________ City: ___________________ Zip: ____________

Phone: (H) ____________________ (W) ____________________ (Cell) ____________________

How did you learn about the program? ____

I attest that the information provided above is accurate to the best of my knowledge.

Signature: ____ Date: _______________________

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Participation and Liability Release, Photo Release and Authorization for Emergency Medical Treatment

Liability Release

I ____(Participant's Name) would like to participate in program(s) offered by Leap O' Faith Therapeutic Riding Center, Inc. as a rider and/or volunteer. I acknowledge the risks and potential risks of working with horses and horseback riding. Under Oklahoma 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. However, I feel that the possible benefits to myself/my child/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs, and assigns, executors or administrators, waive and release forever all claims for damages against Leap O' Faith Therapeutic Riding Center, Inc., it's Board of Directors, Instructors, Therapists, Aides, Center Property Owner, Volunteers and/or Employees for any and all injuries and/or losses I may sustain while participating in program(s) offered by Leap O' Faith Therapeutic Riding Center, Inc.,

Date:__________________ Signature:____
Participant (if over 18) or Participant's Parent or Guardian

Photo Release

I DO☐ I DO NOT☐ consent to and authorize the use and reproduction by Leap O' Faith Therapeutic Riding Center, Inc. of any and all photographs and any other audio/visual materials taken of myself/my child/my ward for promotional material, educational activities, and exhibitions *or* for any other use for the benefit of the center.

Date:__________________ Signature:____
Participant (if over 18) or Participant's Parent or Guardian

Authorization for Emergency Medical Treatment, In the event of an emergency, contact:

Name: ________________________________Relation: ______________Phone: __________________
Name: ________________________________Relation: ______________ Phone:__________________

Consent Plan

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 Leap O' Faith Therapeutic Riding Center, Inc., I authorize Leap O' Faith Therapeutic Riding Center, Inc. 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-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:__________________ Signature:____
Participant (if over 18) or Participant's Parent or 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. Parent or legal guardian will remain on site at all times during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

Date:__________________ Signature:____
Participant (if over 18) or Participant's Parent or Guardian

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INFORMATION FOR PHYSICIAN/TEACHER/THERAPIST

Participant's name: ____

One of your patients is interested in participating in equine-assisted activities and therapies at Leap O' Faith Therapeutic Riding Center, Inc. Attached you will find an assessment and/or health history form which will help our instructors develop a safe and effective program for him/her. In order to participate in the equine-assisted activities and therapies at Leap O' Faith Therapeutic Riding Center, Inc., we must have a signed Physician's Assessment and Health History. Please fill out the areas that pertain to your expertise, and/or attach any existing assessments or reports that you think will be helpful to our staff.

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
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown
Weight Control Disorder

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders

Equine-assisted activities and therapies are a unique and productive way to improve the lives of many children and adults with physical, cognitive or psychological disabilities. Your participation in our program is invited. Please feel free to call or visit Leap O' Faith Therapeutic Riding Center, Inc. if you would like more information. Thank you very much for your assistance.

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PHYSICIAN ASSESSMENT & HEALTH HISTORY

~~To be completed by physician~~

Participant:____

DOB: ______________________Height: __________Weight:_____________ M_____F____

Date of Last Tetanus shot:____

Diagnosis

Primary: ____Date of Onset: __________

Secondary:____ Date of Onset: __________

Past/Prospective Surgeries: ____

Medications:____

Shunt, Implants:____

Special Precautions/Needs:____

Mobility: *(circle)* Independent Ambulation **Y / N**   Assisted Ambulation **Y / N**   Wheelchair **Y / N**
Braces/Assistive Devices:____

Down Syndrome Participants

An Altlantoacial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3.
Date of X-ray:__________ Results:____
Neurologic Symptoms of Atlantoaxial instability:____________________________________

Seizure Disorder Participants

The following information is required for clients with Seizure Disorders. Would you consider this person's seizures to be: ☐Completely controlled ☐Very well controlled ☐Fairly controlled by medication
Type of Seizure: ____
Typical aura:____
Typical motor activity during seizure:____
Duration of seizure:____
Current frequency of seizures: ____
Date of last seizure: ____
Description of Participant's behavior during post-ictal state:________________________________
Post-ictal state duration: ____

Continued on next page. Doctor's signature required.

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PHYSICIAN ASSESSMENT & HEALTH HISTORY CONTINUED

~~To be completed by physician~~

Participant's Name:____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply including surgeries.

Area:	Y	N	Comments:
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Cognitive			
Learning Disabilities			
Behavior			
Emotional/Psychological			

Given the diagnosis and medical information contained in this assessment and health history, this person is not medically precluded from participation in equine assisted activities. I understand the Leap O' Faith Therapeutic Riding Center, Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Leap O' Faith Therapeutic Riding Center, Inc. for ongoing evaluation to determine eligibility for participation. Annual re-evaluation and authorization will be required.

Name/Title:________________________________MD DO NP PA Other__________________

Signature:____Date:_______________

Address:____

Phone: ( ) ____________________________ License/UPIN Number:_______________________