



Horse Sense & Sensitivity
P.O. Box 2301
Jacksonville, FL 32203-2301
Horsesensejax@gmail.com
904-257-6612

Date _____

Dear Participant, Parent or Legal Guardian,

Welcome to Horse Sense and Sensitivity! Whether you are a new or returning participant in our programs, we hope you enjoy the equine activities being made available to you. We look forward to working with you and/or your child this year.

As our organization has grown and developed, it has become very important that we collect and maintain consistent documentation on all our participants. This is both important for the safety and well-being of all participants as well as for compliance with industry standards for equine assisted activities.

In an effort to make the application process more comprehensive and complete, we have put together a ***Participant Application Packet***. This packet will need to be completed and returned to Horse Sense and Sensitivity. **Please note the pages which will need to be completed by the participant's physician.**

Included in the ***Participant Application Packet*** are:

Pages 1-7 to be completed by Participant/Parent/Guardian

- Application and Health History
- Release from Liability and Release and Indemnity Agreement
- Authorization for Emergency Medical Treatment

Pages 8-9 to be completed by Participant/Parent/Guardian and **GIVEN to the Physician**

- Participant Consent for Release of Information
- Introduction Letter to Participant's Physician

Pages 10-11 to be completed by **the Physician**

- Participant's Medical History and Physician's Statement

Please make every effort to complete and return these forms by _____. We understand it may take longer to get the *Participant's Medical History and Physician's Statement* completed. However, we will need all forms completed and returned **no later than** _____.

Thanks for your help with these important forms. They will help us ensure that you and/or your child have a safe and successful time in the equine activities at Horse Sense and Sensitivity.

Sincerely,

Instructor – Horse Sense & Sensitivity



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Participant's Application and Health History

General Information

Participant Name: _____

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

Address: _____

Day Phone: _____ Cell Phone: _____ E-Mail: _____

Parent/Legal Guardian: _____

Address (if different than above): _____

Phone (if different than above): _____

Employer/School: _____

Address: _____ Phone: _____

Caregivers: _____

Address: _____ Phone: _____

Referral Source: _____ Phone: _____

How did you hear about the program? _____



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Health History/Special Needs

Diagnosis: _____ Date of onset: _____

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

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding) _____

Psycho/Social Function (i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.) _____

Medications (include prescription, over the counter; name, dose, frequency) _____

Goals (i.e. why are you applying for participation? What would you like to accomplish?) _____

Participant Signature: _____ Date: _____

(Signature of Parent/Legal Guardian if participant is under 18)



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Photo Release

I (check one) **DO** **DO NOT** consent to and authorize the use and reproduction by Horse Sense and Sensitivity of any and all photographs and any other audio/visual materials taken of me or my child/ward for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

(Signature of Parent/Legal Guardian if participant is under 18)



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Release from Liability and Release and Indemnity Agreement

We hope you enjoy the equine activities being made available to you. Safety is one of our main concerns, and we conduct all activities with adult supervision. However, since horses are by nature unpredictable Florida law requires us to advise you of the potential danger of equine activities. In order to participate in these activities, it is necessary that we obtain the following release from liability from every adult or the parent/guardian of any person under 18 participating in these activities.

WARNING

UNDER FLORIDA LAW AN EQUINE SPONSOR IS OR PROFESSIONAL IS NOT LIABLE FOR THE INJURY OR DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

Release from Liability

I, _____, understand that equine activities are inherently dangerous. I assume all risks associated with such activities. I hereby release and hold harmless all directors, therapists, instructors, employees, assistants, and volunteers of Horse Sense & Sensitivity, Clark Bailey, Sarah Bailey, Bailey's Farm at 2202 Bishop Estates Road (aka Need More Land and Cattle, Inc. and the Sarah Bailey Farm), Sarah W. Bailey Trust, and any other properties being utilized for HSS activities from all liability resulting from damages or injuries to persons or property, including death, arising from participation in equine activities.

I understand that we are permitted to be at Bailey's Farm, or any other properties being utilized for HSS activities only during the time of scheduled programs and/or when a Horse Sense & Sensitivity representative is present. I agree to enter and exit Bailey's Farm through the designated gate to ensure the privacy of staff and residents. I understand that persons under 18 must be accompanied by an adult. I understand that the horses belong to individual owners and cannot be used at any time other than our scheduled program hours or with the house owner's explicit permission.

RELEASE AND INDEMNITY AGREEMENT

In consideration of the acceptance of my participation and/or the participation of my child or ward in the use of horses during riding sessions provided by or from Horse Sense & Sensitivity, Inc., and with the understanding that a horse may be startled by sudden movement, noise or other factors, and may shy, rear, stop short, bite, buck, kick or run with the rider, especially when the ride is conducted in a natural setting, I **AGREE TO ASSUME THE RISKS** incidental to such participation including, but not limited to, those risks set out above, and, on my own behalf, on behalf of my child or ward, and on behalf of my child's or ward's heirs, executors and administrators, **RELEASE** and forever discharge the released parties defined below, of and from all liabilities, claims, actions, damages, costs or expenses of any nature, arising out of or in any way connected with my participation and/or the



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participation of my child or ward in such horseback riding and further agree to indemnify and hold each of the release parties harmless against any and all such liabilities, claims, actions, damages, costs or expenses, including but not limited to, attorney's fees, disbursements and all expenses incurred in the defense of any actions. The released parties include Horse Sense & Sensitivity, Inc., Clark Bailey, Sarah Bailey, Bailey's Farm (aka Need More Land and Cattle Inc., and the Sarah Bailey Farm), Sarah Bailey W. Trust, any other properties being utilized for HSS activities, their parent related, affiliated and subsidiary companies, and both the current and future officers, individual members of the board of directors, instructors, therapists, volunteers, employees, agents, representatives, successors and assigns of each. I understand that this release of liability and indemnity agreement includes any claims based on negligence, actions or inactions of any of the above released parties and covers bodily injury and property damage, whether suffered by my, my child or ward, before, during, or after such participation. I understand that this release and indemnity agreement includes all claims that the released parties provided the equipment or tack or knowingly or unknowingly provided faulty or defective equipment or tack that was partially or totally responsible for any injuries or damages. I also understand that this release and indemnity agreement includes all claims that the released provided the equine or failed to make efforts to determine the ability of the participant to engage safely in the equine activity or to determine the ability of the participant to safely manage the particular equine based on either mine or the participants' representation of the participant's ability. Further, I understand this release and indemnity agreement includes all claims against the released parties for any injuries or damages arising out of conditions of the land or facilities upon which the participant was injured regardless of whether the conditions were latent or patent. I understand this released and indemnity agreement applies to and is in effect at any and all times that I or my child or ward are participating in any of the equine activities or before, during, or after such participation and applies regardless of whether there have been any changes in the activities or the premises on which the activities take place. I further authorize medical treatment for said child or ward, at my cost, if need arises.

Participant **OR** Volunteer

Name of Participant or Volunteer (**Print**)

Name of Parent/Guardian if participant or volunteer is under 18 (**Print**)

Signature of Participant or Parent/Guardian

Date

Email Address

Phone Number



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Authorization for Emergency Medical Treatment

Participant Volunteer Staff

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 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 the agency, I authorize **Horse Sense and Sensitivity** personnel to:

- Secure and retain medical treatment and transportation if needed.
- 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 "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____

(Participant, Parent or Legal Guardian if participant is under 18)

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 **Horse Sense and Sensitivity**.

- 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: _____

Non-Consent Signature: _____ Date: _____

(Participant, Parent or Legal Guardian if participant is under 18)



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Participant Consent for Release of Information

I hereby authorize: _____
(person or facility – physician, therapist, etc.)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: _____
(Horse Sense and Sensitivity or instructor'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
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Other: _____
- Individual Habilitation Plan (I.H.P)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____
(Signature of Parent/Legal Guardian if participant is under 18)

Print Name: _____

Relation to Participant: _____

Please send materials to (check one):

Participant's Address: _____

Instructor: _____
c/o Horse Sense and Sensitivity
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Introduction Letter to Participant's Physician

Date: _____

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities.

In order to safely provide this service, **Horse Sense and Sensitivity**, requests that you complete/update the attached ***Participant's Medical History & 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
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II Malformations/Tethered Cord/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photo-sensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Blood Pressure Control
Physical/Sexual/Emotional Abuse
Dangerous to Self or Others
Exacerbation of Medical Conditions (i.e. R.A., M.S.)
Fire settings
Hemophilia
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 your patient's instructor.

(Therapeutic Riding Instructor's name and phone number)



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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: Atlanto Axial Instability: _____

Please indicate current special needs in the following systems/areas:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			



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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 the Instructor from Horse Sense and Sensitivity will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Instructor from Horse Sense and Sensitivity for ongoing evaluation to determine eligibility for participation.

Name/Title: _____

MD_____ DO_____ NP_____ PA_____ Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UIPI Number: _____