



Office Use Only:
Application Date: ____/____/____

CLIENT APPLICATION

GENERAL INFORMATION

Applicant Name: _____ Check: Male Female

Height: _____ Weight: _____ Date of Birth: ____/____/____

Parent/Legal Guardian: _____ Ethnicity: _____
Not required; for grant application purposes only.

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____ City: _____ State: ____ Zip Code: _____

County: _____ E-Mail: _____
Used for notification, newsletters, etc.

Name of Current School: _____

Referral Source: _____

Name of Your Employer: _____
Used for grant application purposes

****Every applicant must have page 1-7 completed along with a doctor signed diagnosis (page 8 & 9) to be put on our waiting list.**

If the applicant is a Victim of Abuse, Battered Women, this does not apply.

Is the applicant a Victim of Abuse, Battered Women? Yes No

SCHEDULING INFORMATION

DURING SESSION, NORMAL LESSON TIMES ARE SATURDAY FROM 8:00 AM – 7:00 PM THERE MAY BE A NIGHT DURING THE WEEK THAT MAY BE ABLE TO BE WORKED OUT. EACH STUDENT RIDES ONE TIME PER WEEK ON THE SAME DAY, AND AT THE SAME TIME; EACH LESSON LASTS FROM 1 HR. (including grooming and tacking up)

For scheduling purposes, please fill in ALL the times you or your child will be available to ride on each day. (We will choose one day and time for you or your child to ride on a weekly basis)

Monday: _____ Friday: _____
Tuesday: _____ Saturday: _____
Wednesday: _____ Sunday: _____
Thursday: _____

Return To:
SpiritHorse Therapeutic Center of SW Washington – PO Box 193 Ridgefield, WA 98642
client@spirithorseswwa.org PHONE: (360)887-3452 www.spirithorseswwa.org

APPLICANT HEALTH HISTORY

Please indicate current/past problems in the following areas (Please include triggers, if any):

Vision: _____

Hearing: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Emotional: _____

Behavioral: _____

Pain: _____

Bone/Joint: _____

Muscular: _____

Thinking/Cognitive: _____

Allergies: _____

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APPLICANT HEALTH HISTORY (continue)

Current Medications of Applicant (over-the counter included):

Please describe applicant's FUNCTIONAL abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

***Please describe assistance required or equipment needed:**

Please describe applicant's SOCIAL abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

***Please describe assistance required or equipment needed:**

APPLICANT INFORMATION

Goals (reason for applying; what would you like to see accomplished):

**Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings)
(Dislikes: pets, sounds, etc.):**

What types of things work best for the applicant in terms of rewards and motivation?

How does the applicant best communicate with others?

- Spoken Language Written Language
 Sign Language ASL E/E Communication device
 Combination of the above (please describe)

Does the applicant use:

- Echolalia (repeating words without regard for meaning)
 Stemming (rocking, spinning, hand flapping)
 Self-Regulatory Behavior (Please describe how the applicant uses this self-soothing behavior):

Do changes in the applicant's environment affect their behavior?

- Never Sometimes Frequently

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Applicant's Name: _____ Date of Birth: ____/____/____ Phone: (____)_____

Applicant's Address: _____ City: _____ State:____ Zip Code:_____

Medical Facility:_____ Phone: (_____)_____

Physician's Name:_____ Phone: (_____)_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

Current Medications: _____

Emergency Contacts:

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

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 SpiritHorse Therapeutic Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

*(Please sign the CONSENT PLAN or the NON-CONSENT PLAN on next page)

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Consent Plan

I **DO** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed “lifesaving” by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/____/____

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. In the event emergency treatment aid is required; I wish the following procedures to take place:

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/____/____

PHOTO AND VIDEO CONSENT

I, _____ consent _____ or **do not** consent _____ to authorize the use and reproduction by SpiritHorse Therapeutic Center of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/____/____

SPIRITHORSE THERAPEUTIC RIDING CENTER
RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date ____/____/____ and for thereafter between Scott Weaver, Chris Weaver, SpiritHorse Therapeutic Center, it's Board of Directors, Guarantors, Instructors, Therapists, Aides, Volunteers and/or Employees and _____
(The Participant); and, if Participant is a minor, their Parent or Legal Guardian _____.

In return for use, today and on future dates, of the property, facility and services of the Executive Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his/her horse if he/she owns or leases one, personal property, and him/herself.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence upon SpiritHorse Therapeutic Center, and the Executive Director's Property and Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
3. Participant agrees to hold SpiritHorse Therapeutic Center, the Executive Director and all its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon SpiritHorse Therapeutic Center, and the Executive Director's property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.
5. Participant agrees to indemnify and defend SpiritHorse Therapeutic Center and the Executive Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon SpiritHorse Therapeutic Center and the Executive Director's property or facility.
6. Participant agrees to abide by all of SpiritHorse Therapeutic Center's and the Executive Director's safety rules and regulations.
7. If Participant is using his/her horse, the horse shall be free from infection, contagious or transmittable disease. SpiritHorse Therapeutic Center and the Executive Director reserve the right to refuse horse if not in proper health, or is deemed dangerous or undesirable.
8. This contract is non-assignable and non-transferable, and is made and entered into in the State of Washington, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When SpiritHorse Therapeutic Center, the Executive Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.
9. The Equine Activity Liability laws of the State of Washington, § RCW 4.24.540, state among its statutory provisions that "an equine activity sponsor or an equine professional shall not be liable for an injury to or the death of a participant engaged in an equine activity."

Signature: _____ Date: ____/____/____

If under 18 years of age, parent/guardian signature required below.

Signature: _____ Date: ____/____/____

PHYSICIAN'S PRESCRIPTION

(To be filled out by physician only)

Dear Physician:

Your patient _____ is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

- Atlantoaxial Instability - include neurologic symptoms
- AAP guidelines: < 4.5mm
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossifications
- Joint Subluxation Dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Fusion / Fixation
- Spinal Instability /Abnormalities

NEUROLOGIC

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

OTHER

- Indwelling Catheters
- Medications - i.e. photosensitivity
- Skin Breakdown

MEDICAL/PSYCHOLOGICAL

- Allergies
- Animal Abuse
- Physical/Sexual Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions
- Fire Settings
- Heart Conditions
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorder
- Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below. Sincerely, SpiritHorse Therapeutic Riding Center

Physician's Prescription

Client's Name: _____ Phone: (_____) _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by SpiritHorse Therapeutic Center.

Recommended Frequency:

Precautions:

Physician's Signature: _____ Date: ____/____/____

MEDICAL HISTORY & PHYSICIAN'S STATEMENT

(To be filled out by physician only)

Applicant Name: _____ Male Female Date of Birth: ___/___/___
Height: _____ Weight: _____ Diagnosis: _____
Date of Onset: ___/___/___ Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Yes No Date of Last Seizure: ___/___/___
Shunt Present: Yes No Date of Last Revision: ___/___/___
Special Precautions/Needs: _____

Mobility:

Independent Ambulation: Yes No Wheelchair: Yes No
Assisted Ambulation: Yes No Braces/Assistive Devices: _____

For Those With Down Syndrome:

AtlantoDens Interval X-Rays, Date: ___/___/___ Results: _____
Neurologic Symptoms of AtlantoAxial Instability: _____

PLEASE INDICATE CURRENT/PAST DIFFICULTIES IN SYSTEMS/AREAS; INCLUDE SURGURIES:

Auditory: _____
Visual: _____
Tactile Sensation: _____
Speech: _____
Cardiac: _____
Circulatory: _____
Integumentary/Skin: _____
Immunity: _____
Pulmonary: _____
Neurologic: _____
Muscular: _____
Balance: _____
Orthopedic: _____
Allergies: _____
Learning Disability: _____
Cognitive: _____
Emotional: _____
Pain: _____
Other: _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above, against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ License/UPIN #: _____

Signature: _____ Date: ___/___/___

PHYSICAL/OCCUPATIONAL THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

Client Name: _____ DOB: ____/____/____ Age: _____

Address: _____

Diagnosis: _____ Date of Request: ____/____/____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

Physical/Occupational Therapist (Please Sign)

_____/_____/_____
Date

SPECIAL EDUCATION TEACHER QUESTIONNAIRE

(To be filled out by special education teacher only)

Client Name: _____ DOB: ____/____/____ Age: _____

Address: _____

Diagnosis: _____ Date of Request: ____/____/____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Cognitive and/or Behavioral Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

Special Education Teacher (Please Sign)

_____/_____/_____
Date

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BEHAVIORAL THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

Client Name: _____ DOB: ____/____/____ Age: _____

Address: _____

Diagnosis: _____ Date of Request: ____/____/____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Behavioral Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

Behavioral Therapist (Please Sign)

_____/_____/_____
Date

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SPEECH THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

Client Name: _____ DOB: ____/____/____ Age: _____

Address: _____

Diagnosis: _____ Date of Request: ____/____/____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Speech Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Oral Motor Activities:

Any Helpful Hints for Working with This Person:

Speech Therapist (Please Sign)

_____/_____/_____
Date



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