4STEPS Therapeutic Riding Program
5367A Sixty Foot Road Parsonsburg Maryland 21849 410-835-8814
www.4stepstrp.org ***email giddyup4steps@aol.com***

Participants Application and Health History

To be completed by the participant, parent/legal guardian, or caregiver

GENERAL INFORMATION

Participant_____

Date of Birth: _____Age :_____ Height:_____Weight: _____ M F

Address:_____
_____

Phone:Home _____(Cell)_____Work: _____

email: _____

Employer/School_____
Address: _____
_____Phone: _____
Parent/Guardian/Caregiver_____
Address (if different than above): _____
_____Phone:_____

Referral Source: _____How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Yes/No	Comments
Vision		
Hearing		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional		
Behavioral		
Pain		
Bone/joint		
Muscular		
Thinking/cognitive		
Allergies		

What medications are you currently taking, including over the counter medications?

_____
_____

Reviewed by _____Date _____

This information must be kept current. You will receive replacement forms every year in January. Please furnish updated information whenever there is a change.

Please make sure to fill out the other side of this form

Describe your abilities/difficulties in the following areas. Include assistance required or equipment needed

FUNCTION (mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____
_____

SOCIAL (work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears, concerns, etc…)

_____
_____
_____
_____
_____
_____

GOALS: (ie, why are you applying for participation? What would you like to accomplish?)

_____
_____
_____
_____
_____
_____

LIABILITY RELEASE

In consideration of 4STEPS TRP allowing my participation in this activity I agree to hold harmless and release 4STEPS TRP from legal liability except in the event of 4STEPS TRP gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against 4STEPS TRP for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me in relation to the premises and operations of 4STEPS TRP to include while learning about riding, or while riding, handling, or otherwise being near horses owned by or in the care, custody and/or control of 4STEPS TRP. Having received the participant's manual, I UNDERSTAND THE ASSUMPTION OF RISK.

Name (Print) _____Relationship to rider_____

Signature _____Date _____

PHOTO RELEASE

I DO ☐
I DO NOT ☐

consent to and authorize the use and reproduction by 4STEPS TRP of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Name (Print)_____Relationship to rider_____

Signature_____ Date_____

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Authorization for Emergency Medical Treatment Form

____ Participant ____ Staff ____ Volunteer

Name: _____ DOB:___ _____ Phone: _____

Address: _____

Physician's Name: _____Medical Facility: _____

Health Insurance Company:_____ Policy #:_____
Allergies to
medications_____

Current medications: _____

In the event of an emergency, contact:

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 4STEPS TRP 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.

Consent Plan 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: _____ Consent Name (please print)_____

Consent Signature _____
Client, Parent, Legal Guardian, or Caregiver Signed in presence of center staff

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:_____ Non-Consent Name (please print)_____

Non-Consent Signature _____
Client, Parent, Legal Guardian, or Caregiver Signed in presence of center staff

TAKE THIS FORM TO YOUR LOCAL EMERGENCY ROOM TO ASSURE THAT ALL PERTINENT INFORMATION IS PRESENT

Reviewed by _____Date _____

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MUST BE FILLED OUT AND SIGNED BY YOUR PHYSICIAN

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: AtlantoDens Interval X-rays, Date: _____ Result: + --
Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	YES/NO	COMMENTS
Auditory		
Tactile		
Speech		
Vision		
Cardiac		
Circulatory		
Skin		
Pulmonary		
Immune		
Neurologic		
Muscular		
Balance		
Orthopedic		
Allergies		
Learning disability		
Cognitive		
Emotional/psychological		
Pain		
Other		

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation in determining eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address:_____
Phone: _____ License/UPIN Number: _____

Reviewed by_____Date_____

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