PARTICIPANT APPLICATION REGISTRATION

Participant Name:_____ DOB:_____

Diagnosis: _____ Onset: _____

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

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____(h) _____(w) _____(cell)

Employer/Duty Station_____

Address: _____

Telephone: _____(h) _____(w) _____(cell)

Email: _____ Referral Source: _____

Telephone: _____ How did you hear about **EQUI-VETS**? _____

Participant Health History

Please indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Fear/aversion to animals			

Medications (include prescription, over-the-counter; name, dose and frequency, side effects encountered):

Describe your abilities/difficulties in the following areas (including assistance required or equipment needed):

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

Psycho/Social Function (work/school including grade completed, leisure interests, relationship-family structure, support system, companion animals, fears/concerns, etc):

Goals (Why are you applying to participate? What would you like to accomplish?):

Dated: _____ _____

EQUI-VETS Participant

Date:_____

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and 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
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

OTHER

Indwelling Catheters/Medical Equipment
Medications - i.e. Photosensitivity
Poor Endurance
Skin Breakdown

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
Weight Control Disorders

Thank you very much for your assistance. Should you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,
Kathy Chitwood, RN,BC
Program Director
EQUI-VETS Service Program
2626 Heritage Park Drive
Virginia Beach VA 23456
757-721-7350 (phone)
757-721-7354 (fax)

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant Name_____ 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 Atlanto Axial Instability: _____

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

			Comments
Auditory:	Y	N	_____
Visual:	Y	N	_____
Tactile Sensation:	Y	N	_____
Speech:	Y	N	_____
Cardiac:	Y	N	_____
Circulatory:	Y	N	_____
Integumentary/Skin:	Y	N	_____
Immunity:	Y	N	_____

			Comments
Pulmonary:	Y	N	_____
Neurologic:	Y	N	_____
Muscular:	Y	N	_____
Balance:	Y	N	_____
Orthopedic:	Y	N	_____
Allergies:	Y	N	_____
Learning Disability:	Y	N	_____
Cognitive:	Y	N	_____
Pain:	Y	N	_____
Emotional/Psychological:	Y	N	_____

Other:_____

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 EQUI-VETS Service Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to EQUI-VETS for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (_____)_____ License/UPIN Number: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
EQUI-VETS PARTICIPANT

In the event emergency medical aid treatment is required due to illness or injury during the course of participating with the **EQUI-VETS Service Program**, or while being on said premises of the organization, I hereby authorize **EQUI-VETS Service Program** and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed; and
2. Release client records upon request to the authorized agency or its representative involved in the medical emergency treatment

Participant Name:_____ Telephone:_____
Address:_____ City/State/ZIP:_____

In the event that I am unconscious, please contact:

Name:_____ Telephone:_____
Relationship:_____
Physician's Name:_____ Telephone:_____
Medical Facility:_____ Telephone:_____
Health Insurance Company:_____ Telephone:_____

In an effort to provide the best care possible, please indicate below:

I am allergic to the following medications: _____

I have the following ongoing medical conditions: (i.e.: Diabetes, Seizures, etc):

_____

Date:_____ _____
EQUI-VETS Participant

NON-CONSENT FOR MEDICAL TREATMENT

I **DO NOT** give consent for emergency medical treatment for myself in the case of illness or injury during the course of participating in the lesson program or while on the premises of the **EQUI-VETS Service Program.**

In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

Date:_____ _____
EQUI-VETS Participant

Printed Name:_____
Address:_____
City, State, Zip:_____
Phone:_____

Revised: 5/2011

PARTICIPANT RELEASE AGREEMENT

I, _____the undersigned adult participant, for and in consideration of the agreement of the **EQUI-VETS Service Program**, *a subsidiary of EQUI-KIDS Therapeutic Riding Program*, to provide equine-assisted activities and/or riding instruction for myself, do hereby forever release, acquit, discharge, and hold harmless **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever, which I may now or in the future have against the **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, or assigns on account of any personal injuries, physical or mental condition, known or unknown, to myself, and the treatment thereof, as a result of, or in any way growing out of the acts of the **EQUI-VETS Service Program** and the **EQUI-KIDS Therapeutic Riding Program**, its officers, trustees, agents, employees, representatives, successors, or assigns, including but not limited to their negligence or gross negligence, in rendering the services above described or in any way incidental thereto. In accordance with Act 3.1-796.132 of the Code of Virginia, notice is hereby given on the intrinsic dangers of equine activities, including (i) the propensity of an equine to behave in dangerous ways which may result in injury to the participant; (ii) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and (iii) hazards of surface or subsurface conditions.

Date:_____ _____

EQUI-VETS Participant

PARTICIPATION POLICY AND PROCEDURES

1. The purpose of therapeutic riding lessons shall be to foster positive self-awareness by all participants and allow for outdoor recreational opportunities for disabled service men and women.
2. Every attempt will be made, each session, to provide therapeutic riding lessons to new participants depending upon the availability of the class, disability of the participant and/or competence of the therapeutic riding instructor in that particular field of teaching.
3. It is our policy that once a session begins, classes are closed and shall remain so until the next series of lessons is open for registration. To incorporate new participants at various stages during these lessons not only detracts from the progress in that particular class, it does not allow for proper interaction between the new participant and the instructor. New participant orientation will be scheduled prior to every session to introduce new participants to the facility, instructors and horses; however, should there be a scheduling conflict the participant will be introduced to the program on the first lesson.
4. The EQUI-VETS Service Program is free to participants. Individuals interested in recreational/therapeutic riding must contact the Program Director to develop a lesson schedule suitable to meet the needs of the participant and the abilities of EQUI-VETS to provide the service.
5. Participants are encouraged to be ready for their lessons and arrive on time. Participants who are ten or more minutes late will not be permitted to take part in the lesson. If you are unable to attend a class, please contact our office or the instructor prior to your lesson day at the number below. Riders who accumulate three (3) unexcused absences in a lesson session will be removed from the program and fees are non-refundable.

EQUI-VETS/EQUI-KIDS Office: 757-721-7350

6. Lessons will be held rain or shine. For severe weather conditions, such as hurricanes, severe lightening, snow, or tornados, participants will be contacted and make-up lessons will be scheduled. It is EQUI-VETS policy that make-up lessons may only be scheduled due to severe weather conditions, facility disruptions, or other unforeseen events. Make-up lessons will not be provided for missed lessons.
7. Family members under the age of 18 must be accompanied by an adult at all times.
8. Due to the nature of therapeutic riding, EQUI-VETS rider weight limit is 200 lbs., unless otherwise determined acceptable by the Program Director. The limitation has been established to ensure the soundness and well-being of all program horses and ponies. Special considerations will be reviewed on a case-by-case basis and applicants/participants are encouraged to discuss these considerations with the Program Director.

Date:_____ _____

EQUI-VETS Participant

Revised: 2/2011

PHOTOGRAPH AND MEDIA RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to the **EQUI-VETS Service Program,** *an affiliate program offered by EQUI-KIDS THERAPEUTIC RIDING PROGRAM*, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television pictures of myself _____, and consents and authorizes the **EQUI-VETS Service Program**, and its affiliates, advertising agencies, news media and any other persons interested in the **EQUI-VETS Service Program**, and its work, to use and reproduce the photographs, films, and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research materials and books.

With respect to the foregoing matters, no inducements or promises have been made to me to secure my signature(s) to this release other than the intention of the **EQUI-VETS Service Program,** to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding the program and its mission.

Dated: _____ _____

EQUI-VETS Participant

NON-CONSENT FOR PHOTOGRAPH

For reasons that I am not obligated to disclose, ***I DO NOT GIVE CONSENT*** for photographs, either still or moving, or any television or news media, to be taken of myself by the **EQUI-VETS Service Program** or any persons working on behalf of said program. I understand that a **RED MARK** will be placed on the record kept in the administrative offices of the program, which will designate that photographs are not allowed of myself or said person.

Dated: _____ _____

EQUI-VETS Participant