HORSES FOR HEALING TRC
Mailing Address: P.O. Box 4839 * Auburn, CA 95604 * Voice (530) 887-9573
Riding Center: Center Stage * 13355 Bell Brook Drive * Auburn, CA 95602

Participant's Application and Health History

APPLICATION DATE: _____

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Alternative #: _____

Email Address: _____@_____

Employer/School: _____

Address: _____

Phone: _____ Alternative #: _____

Parent/Guardian Name: _____

Contact Numbers: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset: _____

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communications			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency):*

Describe your 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.)***:**

GOALS **(i.e. Why are you applying for participation? What would you like to accomplish?):**

Signature: _____ Date: _____

PHOTO RELEASE

☐ I DO ☐ I DO NOT

Consent to and authorize the use and reproduction by Horses For Healing (center).

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.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Signed in the presence of center staff

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Authorization for Emergency Medical Treatment Form

__ Participant __ Staff __ Volunteer

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: _____

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 ___Horses For Healing____ to:
(Center's Name)

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 Signature: _____
Client, Parent or Legal Guardian
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 is required, I wish the following procedures to take place:

_____
_____
_____

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

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

PARTICIPANT TREATMENT AUTHORIZATION

HORSES FOR HEALING TRC

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RELEASE OF LIABILITY

Participant _____ Telephone _____

Address _____

City, State, Zip _____

E-Mail _____ @ _____

I acknowledge that horses are large animals and horseback riding is a sport which carries inherent risks of injury and damage to myself, my child, persons in my care, a horse and property belonging to the Horses For Healing Therapeutic Riding Center (hereafter referred to as HFH) and others. I knowingly assume all risks of injury and damage, whether known or unknown, of horseback riding.

In consideration of my participating in events organized or sponsored by HFH, I hereby release HFH from all liability whatsoever, specifically including for example any act of negligence or want of ordinary care on the part of HFH or any of its agents, volunteers, servants, members, employees, officers and directors, and I waive, release and discharge HFH and its agents, volunteers, servants, members, employees, officers and directors from any and all claims of liability for injury or damage to myself, my child, persons in my care or my property arising out of participation in events organized or sponsored by HFH. This agreement is binding upon my personal representatives, guardians, conservators, successors, administrators, executors, heirs and assigns.

I expressly waive any rights I may have under California Civil Code 1542, which states: "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him might have materially affected his settlement with the debtor."

I agree that I will defend, indemnify and hold harmless HFH, its officers, members, volunteers, employees, servants, directors, and agents against all claims, demands, and causes of action, including court costs and actual attorney fees, arising from any legal proceeding of any character or lawsuits prosecuted against HFH arising out of in any manner whatsoever my participation in events organized or sponsored by HFH irrespective of any negligence or alleged negligence of HFH. My obligation to defend HFH will commence immediately after the earlier of a claim for damages being made against HFH, commencement of any legal proceeding of any character, or the filing of a lawsuit prosecuted against HFH.

HFH, its agents or employees, shall not be liable for any damage, which may accrue from any cause or as a result of fire, theft, running away, state of health, injury to person, horse or property.

I acknowledge that I have read this Release of Liability and know and understand its contents.

I acknowledge that all riders will be required to wear a safety helmet while riding in the HFH program so as to help prevent horse related head injuries.

Signature: _____Date: _____

MINORS DO NOT SIGN THIS FORM

PARENT OR LEGAL GUARDIAN MUST COMPLETE THIS SECTION

I, the undersigned parent/caregiver of the above participant in consideration of my minor's participation in the event, agree that the terms and conditions of this Release of Liability shall be binding as to damage or injury to my minor and property arising out of his/her participation in this program. I acknowledge that I have read this Release of Liability and know and understand its contents.

Print Name: _____ _____ Telephone: _____

Address: _____

Signature: _____ Date: _____

PARTICIPANT RELEASE OF LIABILITY

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Participant's Consent for Release of Information

I hereby authorize:

_____
(person or facility)

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

The information is to be released to: _____Horses For Healing__ _____
(center or therapist'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
- ¡ Occupational Therapy evaluation, assessment and program plan
- ¡ Speech Therapy evaluation, assessment and program plan
- ¡ Mental Health diagnosis and treatment plan
- ¡ Individual Habilitation Plan (I.H.P.)
- ¡ Classroom Individual Education Plan (I.E.P.)
- ¡ Psychosocial evaluation, assessment and program plan
- ¡ Cognitive-Behavioral Management Plan
- ¡ Other: _____

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

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to:

_____

_____

_____

_____

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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: 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:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
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 equine assisted activities. I understand that the PATH International center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International center for ongoing evaluation to determine eligibility for participation.

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

PHYSICIAN'S STATEMENT

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Date: _____

Dear Health Care Provider:

Your patient, _____
(participant's name)

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
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

Age - under 4 years
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 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 the center at the address/phone indicated above.

Sincerely,