Boots and Buddies Therapeutic Riding

203-733-6657

Student's Application and Health History

GENERAL INFORMATION

Participant name: _____

Date of birth:_____ Age_____

Height:_____ Weight:_____ Gender M ☐ F ☐

Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ H/W/C

Alternate Phone: _____ H/W/C

Participant's employer/school:_____

Mother/Guardian: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Father/Guardian: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

How did you hear about the program? _____

Are you or someone you know a veteran or a member of the armed forces? Yes ☐ No ☐

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Student's Application and Health History (cont'd.)

HEALTH HISTORY

Diagnosis: _____ Date of onset: _____

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

Area	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Asthma/Respiratory			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

List all of participant's current prescription and over-the-counter medications/ supplements, including dose and frequency:

_____
_____
_____
_____
_____
_____
_____

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Student's Application and Health History (cont'd.)

Describe abilities/difficulties in these areas (include assistance required or equipment needed):

Physical function(e.g. mobility functions such as transfers, walking, wheelchair use, riding):

_____
_____
_____
_____
_____
_____
_____
_____

Psycho-social function(e.g. work/school, including grade completed; leisure interests; relationships/family structure; support systems; companion animals; fears/concerns):

_____
_____
_____
_____
_____
_____
_____
_____

Goals (e.g. reasons you are applying for participation and what you would like to accomplish):

_____
_____
_____
_____
_____
_____
_____
_____

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Student's Application and Health History (cont'd.)

Would you be willing/able to take your child out of school early in order to participate in our programs? Yes ☐ No ☐

Additional comments:

_____
_____
_____
_____
_____
_____

In addition to riding, some students also choose to participate in unmounted sessions to learn general horsemanship skills and experience bonding with therapeutic animals.

Please check here if you are interested in these programs: ☐

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Authorization for Emergency Medical Treatment

Participant name: _____

Date of birth:_____ Age_____

Street Address: _____

City: _____ State: _____ Zip: _____

Physician's name: _____

Preferred medical facility: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone(s): _____

Name: _____ Relationship: _____

Phone: _____ Alternate Phone(s): _____

Name: _____ Relationship: _____

Phone: _____ Alternate Phone(s): _____

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Authorization for Emergency Medical Treatment (cont'd.)

If emergency medical aid/treatment is required due to illness or injury during the process of receiving services, I authorize Boots and Buddies Therapeutic Riding 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 emergency medical treatment.

Consent Plan
This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above is(are) unable to be reached.

Date: _____ Consent

Signature:_____
Signature of parent/legal guardian/conservator of participant in his/her name
REQUIRED 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 on the property of the farm associated with the agency. A parent or legal guardian will remain on site at all times during equine-assisted activities. In the event that emergency medical treatment/aid is required, I wish the following procedure to take place:

_____
_____

Date: _____ Non-Consent

Signature:_____
Signature of parent/legal guardian/conservator of participant in his/her name
REQUIRED if participant is under 18

Boots and Buddies Therapeutic Riding

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Liability Release (Required)

_____(**Participant name)** would like to participate in the Boots and Buddies Therapeutic Riding program. I acknowledge the risks and potential for risks of horseback riding and related equine activities, including grievous bodily harm. However, I feel that the possible benefits to myself/my child/my ward are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors, and administrators, waive and release forever all claims for damages against Boots and Buddies Therapeutic Riding, its Board of Directors, Instructors, Therapists, Aids, Volunteers, Employers and/or any farms, stables, clubs and its officers, directors, employees, agents, landowner and members for any and all injuries and/or losses I/my child/my ward may sustain while participating in the program from whatever cause including but not limited to the negligence of these released parties. This hold harmless agreement shall extend to all activities engaged in, including but not limited to equine-assisted therapeutic activities and horseback riding.

I have read and understood the foregoing and fully consent to the provisions contained herein:

Date: _____

Current Signature:_____

Signature of parent/legal guardian/conservator of participant in his/her name

REQUIRED if participant is under 18

Witness signature:_____

Required and must be a non-family member

Print witness name: _____ Date: _____

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Photo Release

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Boots and Buddies Therapy Services, Inc. permission to take or have taken still and moving photographs and films, including television pictures of my child/self, _____ **(Participant Name),** and consents to and authorizes Boots and Buddies Therapeutic Riding, its advertising agencies, news media, and any other parties interested in Boots and Buddies Therapeutic Riding, 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 material, books, clinical material, website and any other form of media.

With respect to the foregoing matters, no inducements or promises have been made to me/us to secure my/our signature(s) to this release other than the intention of Boots and Buddies Therapeutic Riding to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Boots and Buddies Therapeutic Ridng and its work.

[ ] I hereby consent to and authorize
[ ] I do not consent to, nor do I authorize

Date: _____

Signature: _____

Signature of parent/legal guardian/conservator of participant in his/her name
REQUIRED if participant is under 18

Boots and Buddies Therapeutic Riding

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Dear Health Care Provider: Date:_____

In order to safely provide equine-assisted therapeutic services, 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/or contraindications to horseback riding and/or other equine-assisted activities. Therefore, please note whether these conditions are present, and to what degree.

Orthopedic

[ ] Atlantoaxial instability-include neurologic symptom
[ ] Coxa Arthrosis
[ ] Cranial deficits
[ ] Heterotopic Ossification/ Myositis Ossificans
[ ] Joint subluxation/dislocation
[ ] Osteoporosis
[ ] Pathologic fractures
[ ] Spinal Joint Fusion/Fixations
[ ] Spinal Joint Instability/ Abnormalities

Other

[ ] Age- under 4 years
[ ] Indwelling catheters/Medical Equipment
[ ] Medications (i.e. those which cause photosensitivity)
[ ] Poor endurance
[ ] Skin breakdown
[ ] Recent surgeries without physician's clearance

Medical/Psychological

[ ] Allergies
[ ] Animal abuse
[ ] Cardiac condition
[ ] Physical/sexual/emotional abuse
[ ] Blood pressure control
[ ] Dangerous to self or others
[ ] Exacerbations of medical conditions
[ ] Fire settings/pyromania
[ ] Hemophilia/other blood-clotting disorder
[ ] Substance abuse
[ ] Thought Control Disorder
[ ] Weight Control Disorder

Medical Instability

[ ] Migraines
[ ] PVD
[ ] Cord/Hydromyelia Respiratory Compromise

Neurologic

[ ] Hydrocephalus/Shunt
[ ] Spina Bifida/Chiari
[ ] Malformation/Tethered
[ ] Seizure disorders

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.

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Student's Medical History and Physician's Statement

Participant name: _____

DOB:_____ Height:_____ Weight:_____

Street Address: _____

City: _____ State: _____ Zip: _____

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, date of AtlantoDens Interval X-Rays: _____

Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

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Student's Medical History and Physician's Statement (cont'd.)

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

Area	Y	N	Comments
Auditory			
Visual			
Tactile/sensation			
Speech			
Cardiac			
Circulatory			
Intergumentary/skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning disability			
Cognitive			
Emotional/psychological			
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 that this person's abilities/limitations may be reviewed by a licensed/credentialed health professional(e.g., PT,OT, speech therapist, psychologist, etc.) in the implementation of an effective equestrian program. Should direct physical therapy services be warranted, they will be provided by a licensed physical therapist.

Name/Title: _____ MD DO NP PA Other: _____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone: _____ License/UPIN Number: _____

Signature: _____ Date: _____