Angels on Horseback

www.angelsonhorseback.org

A PATH International Center Member

THERAPEUTIC RIDING APPLICATION

Participant's Name: _____ Date:_____

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

Mom (or other guardian):_____ Dad (or other guardian):_____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Email: _____ Email: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

How did you hear about our program? _____

Describe any previous horse/riding experience: _____

In the event of an emergency, contact:

Name: _____ Relation:_____ Phone:_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

☐ CONSENT PLAN: In the event emergency medical aid/treatment is required to due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Angels on Horseback to:

- ★ Perform CPR if student requires it and parent or guardian is not present.
- ★ Secure and retain medical treatment and transportation if needed.
- ★ Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

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.

☐ NON -CONSENT PLAN: I **do not** give my consent for emergency medical aid. I will be ***personally*** responsible for any and all treatment decisions in the event of an emergency.

Date:_____ Signature: _____

Signed by Participant, Parent or Legal Guardian

*** * * PLEASE PROVIDE HEALTH INSURANCE INFORMATION * * ***

INSURANCE COMPANY NAME: _____

POLICY #:_____ **PHONE NUMBER:**_____

PREFERRED MEDICAL FACILITY:_____

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HEALTH HISTORY

Primary Diagnosis: _____ Date of onset: _____

Secondary: _____ Date of onset: _____

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

	Yes	No	Comments
Vision	☐	☐	
Hearing	☐	☐	
Sensation	☐	☐	
Communication	☐	☐	
Heart	☐	☐	
Breathing	☐	☐	
Digestion	☐	☐	
Emotional Health	☐	☐	
Mental Health	☐	☐	
Behavioral	☐	☐	
Pain	☐	☐	
Bone/joint	☐	☐	
Muscular	☐	☐	
Thinking/Cognition	☐	☐	
Allergies	☐	☐	

Please describe Participant's abilities/difficulties in the following areas, including details regarding assistance required or special equipment needed.

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use, driving, etc.) _____

☐Right handed ☐Left handed Affected side: ☐Right ☐Left

Psycho/Social Function (i.e. work/school including grade completed, leisure interests, relationships/family structure, support systems, companion animals, fears/concerns, etc) _____

Preferred learning style(s): ☐visual ☐auditory ☐hands-on

Medications (include prescription, over the counter, name, dose and frequency): _____

Allergies: _____

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

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WAIVER AND RELEASE OF LIABILITY

Participant's Name: _____

--WARNING--

Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

I acknowledge that horseback riding or activities involving horses is an extreme test of a person's physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the most quiet and calm horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself and my executors, administrators, heirs, next of kin, successors and assigns:

a) I waive, release and discharge from any and all claims or liabilities for death, personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from, the horseback riding events, the following persons or entities: Angels on Horseback, Inc., its building or facility owners, sponsors, officers, directors, employees, volunteers, representatives, instructors, fieldhands, and agents of the above.

b) I agree not to sue any of the persons or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and

c) I indemnify and hold harmless the persons or entities mentioned above from any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

I ☐ do ☐ do not consent to and authorize the use and reproduction by Angels on Horseback of any and all **photographs** and any other **audio/visual materials** taken of me for promotional material, educational, exhibitions or for any other use for the benefit of the center.

By signing this form, I affirm that I am of legal age (21 years of age or older), I have read this document, and I understand its contents. This document shall be construed under the laws of the State of Georgia.

_____ _____

Signature of Participant **Date**

The undersigned _____, parent and natural or legal guardian of
name of parent or legal guardian
_____ hereby executes the foregoing Waiver and Release for and on behalf of
participant's name
the minor named herein. I hereby bind myself and all other assigns to the terms of the Waiver and Release. I represent that I have the legal capacity and authority to act for and on behalf of the minor named herein, and I agree to indemnify and hold harmless the persons and entities mentioned above for any claims or liabilities assessed against them as a result of any insufficiency of my legal capacity or authority to act for or on behalf of the minor in the execution of the Waiver and Release.

_____ _____

Signature of Parent or Legal Guardian **Date**

PLEASE RETURN COMPLETED APPLICATION TO ANGELS ON HORSEBACK

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PHYSICIAN'S STATEMENT

Dear Health Care Provider:

Your patient is interested in or is participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the following three page Physician's Statement. Completed forms should be returned to your patient.

Patient's Name: _____ DOB: _____ Age: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____ Pulse: _____ BP: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medications (type, purpose, & dose):_____

_____

_____

*If Down Syndrome, has patient had a complete neurologic exam that shows no evidence of Atlanto-Axial Subluxation? ☐ Yes ☐ No

Do you have certification by a physician that an examination did not reveal atlantoaxial instability or focal neurologic disorder? ☐ Yes ☐ No

Date of last tetanus shot: _____

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing these forms, please note whether any of these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability (include neurologic symptoms)
Coxa Arthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Join Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Other

Age- under 4 years
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance/Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Hemophilia
Migraines
Fire Setting
PVD
Recent Surgeries
Substance Abuse
Respiratory Compromise
Thought Control Disorders
Weight Control Disorders
Medical Instability
Blood Pressure control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Physical/Sexual/Emotional Abuse

PHYSICIAN'S STATEMENT

PROBLEM	YES	NO	IF YES, DESCRIBE
Auditory Impairment	☐	☐	_____
Learning Disability	☐	☐	_____
Mental Impairment	☐	☐	_____
Psychological Impairment	☐	☐	_____
Speech Impairment	☐	☐	_____
Visual Impairment	☐	☐	Glasses: _____
Cardiac	☐	☐	_____
Circulatory	☐	☐	_____
PVD	☐	☐	_____
Postural Hypotension	☐	☐	_____
Hemophilia	☐	☐	_____
Pulmonary	☐	☐	_____
Asthma / COPD	☐	☐	_____
Neurological	☐	☐	_____
Seizures	☐	☐	Type: _____
Controlled?	☐	☐	Date of last seizure: _____
Hydrocephalus	☐	☐	_____
Shunt present?	☐	☐	# Revisions: _____
Sensory Loss	☐	☐	_____
Pain	☐	☐	_____
Muscular	☐	☐	_____
Contractures	☐	☐	_____
Skeletal	☐	☐	_____
Spinal Column Injury	☐	☐	_____
Subluxing Joints	☐	☐	_____
Dislocating Joints	☐	☐	_____
Laminectomy / Fusion	☐	☐	_____
Scoliosis	☐	☐	Degree: _____ Type: _____
			Brace: _____ Last X-ray: _____
Kyphosis / Lordosis	☐	☐	Degree: _____ Type: _____
Spondylolisthesis	☐	☐	_____
Spinal Abnormality	☐	☐	_____
Osteoporosis	☐	☐	_____
Heterotrophis Ossification	☐	☐	_____
Joint Disease	☐	☐	_____
Cranial Defects	☐	☐	_____
Fractures	☐	☐	Location: _____ Healed? _____

PHYSICIAN'S STATEMENT

MOBILITY STATUS

Ambulatory ☐ Yes ☐ No

Can the student ambulate independently? ☐ Yes ☐ No

If no, please explain: _____

_____

_____

PROSTHETICS / ORTHODONTICS

Type: _____ Purpose: _____

Type: _____ Purpose: _____

OTHER:

Please indicate any medical problems not indicated above:

_____

_____

_____

Please indicate special precautions:

_____

_____

_____

PHYSICIAN'S STATEMENT

To my knowledge, there is no reason why _____ cannot participate in supervised equestrian activities. However, I understand that Angels on Horseback will weigh the medical information provided against the existing precautions and contraindications.

participant / patient's name

Physician's Printed Name: _____ MD DO NP PA Other: _____

Office Address: _____

Phone Number: _____ License/UPIN Number: _____

Physician's Signature: _____ Date: _____

Once completed and signed, please return ***all three pages*** of this Physician's Statement to your patient.

If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Tammy Hermann at Angels at Horseback at the telephone number shown below.

Thank you very much for your assistance.

PLEASE RETURN COMPLETED PAPERWORK TO YOUR PATIENT