



The Medicine Horse Center

Equine Assisted Therapies
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

Instructions for Equine Assisted Psychotherapy Application

The following forms are to be filled out by the following persons:

Page 1 – Instructions

Page 2 – Client or Parent/Guardian

Page 3 – Client or Parent/Guardian

Page 4 – Client or Parent/Guardian

Page 5 – Client or Parent/Guardian

Page 6 – Client or Parent/Guardian

Page 7 – Client or Parent/Guardian. Co-Signature required by Client's Referring Therapist

Page 8 – Client or Parent/Guardian

Page 9 – Client's Referring Therapist

Page 10 – Client's Referring Therapist

All forms must be completed in their entirety and submitted to the Medicine Horse Center prior to the first session.



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Participant's Registration and Release Form

Client: _____ Date of Birth: _____ Weight: _____ lbs

****For the safety of our horses, there is a client weight restriction of 180 lbs.****

Street: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work _____ Emergency: _____

Parent/Guardian Name: _____

Address/Phone: _____

School or institution presently attending: _____

In case of emergency contact: _____ Phone: _____

contact: _____ Phone: _____

Photo Release

I hereby consent to and authorize the use and reproduction by The Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

(Participant or Parent/Guardian)



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Participant Liability Release Agreement

I, _____(Client's Name) would like to participate in The Medicine Horse Center's Equine Assisted Therapy Programs. I acknowledge the risks and potential for risks of being around horses. However, I feel that the possible benefits to myself/ my child/ my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against The Medicine Horse Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in The Medicine Horse Center's Therapeutic Riding and Equine Rehabilitation Program.

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LAIBLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERANT RISKS OF EQUINE ACTIVITIES THAT ARE OBVIOUS AND NECESSARY, PURSUANT TO 13-21-119 COLORADO REVISED STATUES.

Signature: _____ Date: _____

(Participant or Parent/Guardian)



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Participant's Authorization for Emergency Medical Treatment

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 *The Medicine Horse Center* to:

- Secure and retain medical treatment and transportation if needed.
- Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Medicine Horse Center harmless for any expenses incurred in my interests.

Name: _____ Phone: _____
Address: _____
Emergency Contact: _____ Phone: _____
Physician's Name and Phone: _____
Preferred Medical Facility: _____
Health Insurance Co.: _____ Phone: _____
Policy #: _____ Group #: _____

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 below is unable to be reached.

Print Name: _____ Phone: _____
Address: _____
Consent Signature: _____ Date: _____
(Participant or Parent/Legal Guardian)

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

Non-Consent Signature: _____ Date: _____
(Participant or Parent/Legal Guardian)

Print Name: _____ Phone: _____

Address: _____





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PARTICIPANT HEALTH HISTORY

Health History

Please describe you/your child's current health status, particularly regarding the physical/emotional demands of participating in an equine program. Specify if there are issues with fitness, cardiac, respiratory, bone or joint function, recent hospitalizations or surgeries.

Height: _____

Weight: _____

Allergies (Medications, Food, Environmental (e.g. bees, horses, hay, grasses etc...)).

Current Medications (Any side effects related to behavior, energy level, sun exposure etc...)

I give my permission for Medicine Horse staff to give allergy medicine (such as Benadryl) to my child, if they are exhibiting signs of an allergic reaction to the horses or the stable environment. Yes _____ No _____

Signature: _____

Date: _____



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Equine Facilitated Psychotherapy Consent for Release of Confidential Information

I, (participant) _____ hereby authorize and request that (therapist) _____ may release to **The Medicine Horse Center** the following information (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Admission for treatment
<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Psychosocial Assessment
<input type="checkbox"/> Treatment Progress Notes
<input type="checkbox"/> Physician Orders | <input type="checkbox"/> Diagnosis
<input type="checkbox"/> Psychological testing results
<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Other _____ |
|---|---|

The purpose of this disclosure is for the development of an Equine Facilitated Psychotherapeutic plan and program. I understand that this authorization will remain in effect until _____ (specify date which is not to exceed 12 months).

This information will be released in the following format (please check all that apply):

- Verbal Via Telephone Handcarried
 Via Mail Via Facsimile (Fax)

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

Participant	Date
Parent or Legal Guardian	Date
Witness	Date
Referring Therapist	Date
Address of Therapist	



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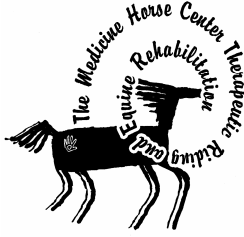
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Therapeutic and Safety Issues

Check and describe applicable issues (indicate current issues, or history of):

- | | |
|--|--|
| <input type="checkbox"/> inattention | <input type="checkbox"/> medical issues |
| <input type="checkbox"/> hyperactivity | <input type="checkbox"/> self-injurious behavior |
| <input type="checkbox"/> lack of concentration | <input type="checkbox"/> suicidal ideations |
| <input type="checkbox"/> learning disabilities | <input type="checkbox"/> history of runaway |
| <input type="checkbox"/> developmentally delayed | <input type="checkbox"/> issues of parental support |
| <input type="checkbox"/> mentally challenged | <input type="checkbox"/> issues of family support |
| <input type="checkbox"/> boundary issues | <input type="checkbox"/> sexual abuse/acting out |
| <input type="checkbox"/> social skills problems | <input type="checkbox"/> history of physical abuse |
| <input type="checkbox"/> problem with peers | <input type="checkbox"/> history of emotional abuse |
| <input type="checkbox"/> separation anxiety | <input type="checkbox"/> hallucinations |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> delusions |
| <input type="checkbox"/> phobias | <input type="checkbox"/> illusions |
| <input type="checkbox"/> aggressive | <input type="checkbox"/> dissociations |
| <input type="checkbox"/> history of assaulting others | <input type="checkbox"/> substance abuse problems |
| <input type="checkbox"/> manipulative | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> unpredictable or dangerous behavior | <input type="checkbox"/> school problems |
| <input type="checkbox"/> sensory impairment | <input type="checkbox"/> history of animal abuse and/or fire setting |
| <input type="checkbox"/> sensitivity, preferences | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> tics or stereotypic behavior | <input type="checkbox"/> possible medication side effects |
| <input type="checkbox"/> psychosomatic symptoms | |



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Mental Health Data Form

Client's Name: _____ Age: _____ DOB: _____

Gender: M or F Height: _____ Weight: _____

Parent/Legal Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

Address: _____ City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Therapist: _____ Phone: _____

Diagnosis (DSM-IV)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Presenting Problems

Current Medications

Drug	Dose	Route	Time	Purpose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Mental Health Data Form (con't)

Psychiatric Treatment History

Where

When

Diagnosis

Current Therapy

Outpatient Therapy

Inpatient Therapy