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

Instructions for Therapeutic Riding 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

Page 8 – Physician or Occupational Therapist

Page 9 – Physician or Occupational Therapist

Page 10 – Physician or Occupational Therapist

Page 11 – Physician or Occupational 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:

_X_ Secure and retain medical treatment and transportation if needed.

_X_ 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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Participant's Consent for Release of Information

I hereby authorize The Medicine Horse Center for Therapeutic Riding and Equine Rehabilitation to release information from the records of:_____DOB:_____
(Participant's Name)
for the purpose of developing a Riding 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:_____

Signature:_____ Date:_____
(Participant or Parent/Guardian)

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Physician's Prescription

Participant's Name:_____Phone:_____

Prescription for Therapeutic Horseback Riding

Prescription for evaluation and treatment by a Physical, Occupational and/or Speech Therapist, or mental health professional in conjunction with The Medicine Horse Center for Therapeutic Riding and Equine Rehabilitation.

Recommended Frequency:_____

Precautions:_____

_____

_____

_____

_____

Physician's Signature:_____Date:_____

Please Print, Type or Stamp

Physician's Name:_____

Address:_____

_____

_____

Phone:_____

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Participant Medical History and Physician's Statement

Name: _____**Date of Birth:**_____

Address:_____

Name of Parent/Guardian:_____

Diagnosis:_____ **Date of Onset**:_____

For Persons with Down Syndrome:

❑Negative Cervical X-ray for Atlantoaxial Instability X-Ray Date: _____

❑Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: (Circle one) Yes / No **Date**:_____ **Height**_____**Weight**:_____

Seizure Type _____ Controlled_____Date of Last Seizure:_____

Please check if patient has a problem or surgeries in any of the following. If yes, please comment.

Areas	Yes	No	Comment
Allergies			
Auditory			
Cardiac			
Circulatory			
Learning Disability			
Mental Impairment			
Muscular			
Neurological			

Areas	Yes	No	Comment
Orthopedic			
Psychological Impairment			
Pulmonary			
Speech			
Visual			
Other			

Mobility: *Independent Ambulation* Y/N *Crutches* Y/N *Braces* Y/ N *Wheelchair* Y/ N

Please indicate any special precautions: _____

_____

_____

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 with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print)_____

Physician Signature _____

Address _____ City_____ State___Zip_____

Phone ( )_____ Date_____

Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

❑ Spinal Fusion _____

❑ Spinal Instabilities _____

❑ Atlantoaxial Instabilities _____

❑ Scoliosis _____

❑ Kyphosis _____

Medical/Surgical

❑ Allergies _____

❑ Cancer _____

❑ Poor Endurance _____

❑ Recent Surgery _____

❑ Diabetes _____

Orthopedic

❑ Lordosis _____

❑ Hip Subluxation and Dislocation _____

❑ Osteoporosis _____

❑ Pathologic Fractures _____

❑ Coxas Athrosis _____

❑ Heterotopic Ossification _____

❑ Osteogenesis Imperfecta _____

❑ Cranial Deficits _____

❑ Spinal Orthoses _____

❑ Internal Orthoses _____

❑ Internal Spinal Stabilization Devices _____

Medical/Surgical

❑ Peripheral Vascular Disease _____

❑ Varicose Veins _____

❑ Hemophilia _____

❑ Hypertension _____

❑ Serious Heart Condition _____

❑ Stroke _____

Neurologic

❑ Hydrocephalus/shunt _____

❑ Spina Bifida _____

❑ Tethered Cord _____

❑ Chiari II Malformation _____

❑ Hydromyelia_____

❑ Paralysis due to Spinal Cord Injury _____

❑ Seizure Disorders _____

Secondary Concerns

❑ Behavior problems_____

❑ Age under two years _____

❑ Age two-four years _____

❑ Acute exacerbation of chronic disorder ____

❑ Indwelling catheter _____