



Equine Assisted Therapies and Experiential Learning
P.O. Box 1074/40700 Road J, Mancos, CO 81328
Tel: 970-533-7403

Instructions for Individual Therapy Application (also known as Equine Assisted Psychotherapy – EAP)

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. Co-Signature required by Client's Referring Therapist.

Page 5 – Client's Referring Therapist

Page 6 – Client's Referring Therapist

***Application must be completed in its entirety and mailed to
Medicine Horse Center Headquarters
prior to first scheduled session***

***Medicine Horse Center
P.O. 1074
Mancos, CO 81328***

Or send digital copy to: info@medicinehorsecenter.org

Medicine Horse Center

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Participant Registration and Release Form

Student: _____ DOB: _____

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

School: _____ Grade: _____

Parent/Legal Guardian Name: _____

Phone Home: _____ Cell/Work: _____

email: _____

In case of emergency contact: _____ Phone: _____

Photo Release

I hereby consent to and authorize the use and reproduction by Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed and/or digital purposes (including social media and web site), educational activities or for any other use for the promotion of Medicine Horse Center and its programs.

Signature: _____ Date: _____
Parent/Legal Guardian

Participant Liability Release Agreement

I, _____ (Parent/Guardian's Name) would like my child to participate in Medicine Horse Center's Equine Assisted Learning Programs. I acknowledge the risks and potential for risks of being around horses, however, I feel that the possible benefits to my child 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 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 Medicine Horse Center's programs.

Please note:

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LIABLE 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 STATUTES.

Signature: _____ Date: _____
Parent/Legal Guardian

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Participant 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 *Medicine Horse Center* to:

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

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

Emergency Contact: _____ Phone: _____

Physician's Name and Phone: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the attending physician(s). This provision will only be invoked if the emergency contact person above is unable to be reached.

Consent Signature: _____ Date: _____
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: _____
Parent/Legal Guardian

Known Allergies or Health Concerns:

*****MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM*****

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Equine Assisted Psychotherapy Consent for Release of Confidential Information

I, *(Parent/Guardian)* _____ hereby authorize and request that **Medicine Horse Center** may discuss necessary medical information with the following clinician:

(please check all that apply):

____ Admission for treatment

____ Diagnosis

____ Psychiatric Evaluation

____ Psychological testing results

____ Psychosocial Assessment

____ Treatment Plan

____ Treatment Progress Notes

____ Discharge Summary

____ Physician Orders

____ Other _____

The purpose of this disclosure is for the development of an Equine Assisted 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

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

Participant

Date

Parent or Legal Guardian

Date

Referring Therapist

Date

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Therapeutic and Safety Issues

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

Page 1 of 6

- | | |
|--|--|
| <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 (con't)

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			
Current Medications			