MEDICINE HORSE CENTER

Horses Helping People

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

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

Participant Registration and Release Form

Student:_____DOB:_____Weight:_____

Address:_____City:_____State:_____Zip_____

Phone: Home:_____Work:_____email:_____

Parent/Legal Guardian Name: _____

Address/Phone:_____

School: _____

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, 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 STATUES.

Signature:_____Date: _____

Parent/Legal Guardian

Medicine Horse Center

Equine Assisted Therapies and Experiential Learning

P.O. Box 1074/40700 Road J, Mancos, CO 81328

Tel: 970-533-7403 info@medicinehorsecenter.org

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*****

Medicine Horse Center

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

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
____ Psychiatric Evaluation
____ Psychosocial Assessment
____ Treatment Progress Notes
____ Physician Orders
___Diagnosis
___Psychological testing results
___Treatment Plan
___Discharge Summary
___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

Medicine Horse Center

Equine Assisted Therapies and Experiential Learning

P.O. Box 1074/40700 Road J, Mancos, CO 81328

Tel: 970-533-7403 info@medicinehorsecenter.org

Therapeutic and Safety Issues

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

___ inattention

___ hyperactivity

___ lack of concentration

___ learning disabilities

___ developmentally delayed

___ mentally challenged

___ boundary issues

___ social skills problems

___ problem with peers

___ separation anxiety

___ anxiety

___ phobias

___ aggressive

___ history of assaulting others

___ manipulative

___ unpredictable or dangerous behavior

___ sensory impairment

___ sensitivity, preferences

___ tics or stereotypic behavior

___ psychosomatic symptoms

___medical issues

___self-injurious behavior

___suicidal ideations

___history of runaway

___issues of parental support

___issues of family support

___sexual abuse/acting out

___history of physical abuse

___history of emotional abuse

___hallucinations

___delusions

___illusions

___dissociations

___substance abuse problems

___legal problems

___school problems

___history of animal abuse and/or fire setting

___seizure disorder

___possible medication side effects

Medicine Horse Center

Equine Assisted Therapies and Experiential Learning

P.O. Box 1074/40700 Road J, Mancos, CO 81328

Tel: 970-533-7403 info@medicinehorsecenter.org

Mental Health Data Form (con't)

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			

Current Medications	