



Thoughtful House
EQUESTRIANS

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Circle: M or F

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

Phone: (____) _____ Alternate #: (____) _____ Email: _____

In case of lesson cancellation, list number and person to contact: _____

Student's Employer/School: _____

Address: _____ Phone: (____) _____ FAX: (____) _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Contact Numbers (if different from above): _____

Referral Source (How did you hear about the program)? _____

HEALTH HISTORY

Participant Diagnosis: _____

Please indicate current or past problems in the following areas:

| | Y | N | Comments |
|--------------------|---|---|----------|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |

Student's Name: _____

What medications is applicant currently taking, including over-the-counter medications?

Describe applicant's abilities/difficulties in the following areas (include assistance required or equipment needed):

FUNCTION (i.e., Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e., Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

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

PHOTO RELEASE

I DO / DO NOT

Consent to and authorize the use and reproduction by **T.H.E. (Thoughtful House Equestrians)** of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Client, Parent or Legal Guardian



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Physician's Prescription

Client's Name: _____ Phone: _____

Prescription for Therapeutic Horseback Riding or Hippotherapy

This is a prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center and NARHA certified instructor.

Recommended Frequency: _____

Precautions: _____

Physician's Signature: _____ Date: _____

Please print, type or stamp

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____



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Date: _____

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability . include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
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
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.



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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ State: _____ Zip: _____ Phone: _____

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval x-rays, date: _____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

| | Y | N | Comments |
|-------------------------|---|---|----------|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

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/credential health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ License/UPIN Number: _____



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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: _____ DOB: _____

Phone: _____ Alternate # _____ Email: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 **T.H.E., Thoughtful House Equestrians** to:

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

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(s) above is unable to be reached.

Date: _____ Consent Signature: _____
Client, Parent or 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 procedures to take place:

Date: _____ Consent Signature: _____
Client, Parent or Legal Guardian

T.H.E. Rules and Regulations

1. Volunteers who work with riders must be physically able to walk and occasionally jog for short distances during the 30-45 minute classes.
2. A parent or designated adult must be on the premises at all times during the time a student is on Angelwylde property participating in a class.
3. Students/Guardians/Parents/Volunteers will be required to sign a variety of forms, including but not limited to a photo release, liability release, emergency medical form, and attending physician forms. Forms must be signed prior to any participation in T.H.E. activities.
4. Volunteers must sign a confidentiality agreement.
5. As of September 1995, Texas enacted the following law:

Texas Law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for the injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

6. Only staff, volunteers and students will be allowed beyond designated visitor areas. Off limit areas include but are not limited to the horse tacking area, barn, horse stalls and pastures, tack room and arena. For the safety of everyone, T.H.E. staff and volunteers will strictly enforce this rule. There is a designated viewing area near the arena for parents and guests.
7. The student, parent, instructor, and volunteers must grant permission prior to any photo taking or video taping.
8. Unsupervised children are not allowed on Angelwylde property. Volunteers should make prior arrangements for childcare. Siblings of students **must** be supervised at all times while on T.H.E. premises.
9. Personal pets are not allowed on the property unless prior arrangements have been made with the instructor and program director.
10. Students and volunteers should dress appropriately for horse related activities. This should include but is not limited to comfortable safe shoes and weather appropriate attire; refrain from wearing excessive perfumes or scented lotions as they may attract bees and other insects.
11. Students and volunteers should be punctual for classes. This is so that everyone can ride for his/her allotted time.
12. Never hand feed treats to horses. Ask for assistance from a volunteer or instructor if you would like to give a food reward to one of the horses/ponies.
13. Please park only in designated areas.

I have read and understand and agree to follow the above rules and regulations set forth by T.H.E., Thoughtful House Equestrians program. I understand and am aware of the Texas Equine Liability Act.

Signature of student, volunteer, parent or guardian*

Date

Print name of student, volunteer, parent or guardian

*If the student is under the age of eighteen a parent or guardian must sign and date for the minor.

**If the volunteer is under the age of eighteen a parent or guardian must also sign this form.

Parent of minor volunteer**

Date



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Liability Release

I, undersigned, adult, student, or parent or guardian of _____ a minor student would like to participate at Thoughtful House Equestrians program. I acknowledge the risks and potential for risks of horseback riding. I understand that I/my son/daughter/ward, will be working with and around horses, as well as, riding horses of T.H.E. However, I feel that the possible benefits to myself/son/daughter/ward are greater than the risk assumed. I, the undersigned student and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damage against Thoughtful House, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which T.H.E. operates, successors or assigns on account of any personal injuries and/or personal damages known or unknown, or in anyway growing out of, the acts of T. H. E., its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which T. H. E. operates, successors or assigns.

I understand that under Texas Equine Liability Act (Chapter 87, Civil Practice and Remedies Code), an 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.

Student signature

Date

If under 18 years, Parent/Guardian Signature

Date