

Buddy Up! Horsemanship and THERAPEUTIC RIDING PROGRAM

Participant's Application

GENERAL INFORMATION:

Participant's Name:

Date of Birth:

Age:

Height:

Weight:

Address:

City:

Zip:

Parent/Guardian:

Home Phone:

Work Phone:

Cell:

Email:

Diagnosis:

Seizures: Yes/No

Physician:

Phone:

Referral Source:

How did you hear about Buddy Up! Horsemanship?:

PHOTO RELEASE (Circle either "I DO" or "I DO NOT")

I DO

I DO NOT

Consent to and authorize the use and reproduction by Buddy Up! Horsemanship and Therapeutic Riding Program of any and all photographs and other audio/visual materials taken of person/child for educational activities, medical progress, promotional material, exhibitions or for any other use for the benefit of the person/child or the program.

Signature:

Date:

Buddy Up! Horsemanship and Therapeutic Riding Program

Participant's Health History

Participant's Name:

Date:

Date of Birth:

HEALTH HISTORY (PAST/PRESENT PROBLEMS)

(Please check and comment on all that apply)

Vision:

Yes/No Explain:

Hearing:

Yes/No Explain:

Sensation:

Yes/No Explain:

Communication:

Yes/No Explain:

Heart:

Yes/No Explain:

Breathing:

Yes/No Explain:

Digestion:

Yes/No Explain:

Elimination:

Yes/No Explain:

Circulation:

Yes/No Explain:

Emotional:

Yes/No Explain:

Behavioral:

Yes/No Explain:

Pain:

Yes/No Explain:

Bone/Joint:

Yes/No Explain:

Muscular:

Yes/No Explain:

Thinking:

Yes/No Explain:

Allergies:

Yes/No Explain:

Cognition:

Yes/No Explain:

What medications is participant currently taking, including over-the-counter medications? (Please list all)

Describe the 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. Work1school including grade completed, leisure interests, relationship family structure, support system, companion animals, fears/concerns animals, rs/concerns:

GOALS (i.e. Why is participant applying? What would participant like to accomplish?)

Buddy Up! Horsemanship and Therapeutic Riding Program

Release and Hold Harmless Agreement

The undersigned assumes the unavoidable risks inherent in all horse related activities, including but not limited to bodily injury and physical harm to horse, rider, and spectator. In consideration, therefore, for the privilege of riding and or working around horses with Buddy Up! Horsemanship and Therapeutic Riding Program operating at Scatter Creek Stables, 4945 165th Lane SW, Rochester, WA, the undersigned does hereby agree to hold harmless and indemnify Buddy Up! Horsemanship and Therapeutic Riding Program and Scatter Creek Stables and further release them from any liability or responsibility for any accident, damage, injury, illness to the undersigned or to any family member or spectator accompanying the undersigned on the premises.

Name (please print):

Address:

Phone Number:

Email Address:

Cell Phone:

Signature (if under 18, parent or guardian signature):

Date:

Witness:

Date:

Buddy up! Horsemanship and Therapeutic Riding Program

Participant's Consent for Release of Information

I hereby authorize:

To release information from the records of:

DOB:

The information is to be released to:

For the purpose of developing a therapeutic riding program for the above named participant.

The information to release is marked below.

Medical History

Physical Therapy evaluation, assessment and or program plan

Occupational Therapy evaluation, assessment and or plan

Speech Therapy evaluation, assessment and or plan

Classroom Individual Education Plan (I.E.P.)

Psychosocial evaluation, assessment and or plan

Cognitive-Behavioral Management Plan

Other (please note below)

Signature:

Date:

Printed Name:

Please send materials to: Buddy Up! Horsemanship and Therapeutic Riding Program

6024 Tiger Tail Dr. SW, Olympia WA 98512

Buddy Up! Horsemanship and Therapeutic Riding Program

Authorization for Emergency Medical Treatment Form

_____ Participant _____ Staff _____ Volunteer

Name: DOB: Phone:

Address:

Physician's Name: Medical Facility:

Allergies to medication:

Current medications:

In event if an emergency, contact:

Name: Relationship: 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, I authorize Buddy Up! Therapeutic Riding Program to:

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

Consent Plan (Sign either consent or non-consent – not both)

The authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure of receiving services or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Consent Signature: Date:

Non-Consent Plan (Sign either consent or non-consent – not both)

I do not give my consent for emergency medical treatment/aid in case of illness or injury during the process of receiving services or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place (specify):

Non-Consent Signature: Date:

Buddy Up! Horsemanship and Therapeutic Riding Program

Participant's Medical History & Physician's Statement

Date:

Dear Physician:

Your Patient, _____, is interested in participating in supervised equestrian activities. In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest special precautions to take place during therapeutic horseback riding:

- Orthopedic Medical/Psychological
- Spinal Fusion/Fixation Hemophilia
- Atlantoaxial Instability (including neurological system)
- Spinal Instability/Abnormalities Medical Instability
- Allergies
- Migraines
- Coxa Arthrosis Animal Abuse
- Neurologic PVD
- Cranial Deficits
- Hydrocephalus/Shunt Respiratory Compromise
- Physical/Sexual/Emotional Abuse
- Seizures Recent Surgeries
- Heterotopic Ossification/Myositis
- Spina Bifida Substance Abuse
- Ossificans Blood Pressure Control
- Chiari II malformation
- Joint sublimation/dislocation
- Tethered Cord
- Dangerous to self or others
- Osteoporosis ' Fire Setting
- Hydromyelia
- Pathologic Fractures Heart Condition
- Other (Specify) _____

Thank you very much for your assistance.

Sincerely,

Buddy Up! Horsemanship and Therapeutic Riding Program

Buddy Up! Horsemanship and Therapeutic Riding Program

Participant's Medical History & Physician's Statement

Name: _____ DOB _____ Height: _____

Weight: _____

Address:

Diagnosis:

Date of Onset:

Past Surgeries:

Medications:

Seizure Types:

Controlled: Yes No

Date of Last Seizure:

Special Precautions/Needs:

Mobility:

Independent Ambulation? Yes No

Assisted Ambulation: Yes No

Wheelchair: Yes No

Braces/Assistive Devices:

For those with Down Syndrome:

AtlantoDens Interval X-rays, date: _____ Result: Positive Negative

Neurological Symptoms of Atlanto Axial Instability:

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

- Auditory

- Visual

- Tactile Sensation

- Speech

- Cardiac

- Circulatory

- Integumentary/Skin

- Immunity

- Pulmonary

- Neurological

- Muscular

- Balance

- Orthopedic

- Cognitive

- Emotional

- Psychological

- Pain

- Other

To my knowledge, there is no reason why this person cannot participate in supervised Therapeutic Riding activities. However, I understand that the Buddy Up! Horsemanship and Therapeutic Riding Program will weigh the medical information above against the existing precautions and contraindications.

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

Signature: _____

Date: _____

Address: _____

Phone: _____

Mobility: _____

Hand skills: _____

Specific limitation in ROM: _____

Muscle tone: _____

Sensory impairments: _____

Hypersensitive Behavioral or emotional considerations:

Visual perceptual difficulties:

Therapeutic goals that may be enhanced by Horsemanship or therapeutic horseback riding include:

Comments/Precautions:
