BLISSFUL DREAMS

935 Blissful Lane

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www.Blissfuldreams.org

Participant Application

PARTICIPANT APPLICATION

In order to ensure safety and coordinated care, Blissful Dreams staff and volunteers are provided with information about participant's abilities/disabilities, all information is otherwise confidential.

Participant's Name____

Primary Diagnosis ____

Date of Birth ___________ **Age** _____ **Height** _____ **Weight** _____ **Gender** _____

School Name____**Grade** _______

Veteran: Y N **Service:** ____

<u>CONTACT INFO:</u>

Parent or Guardian Name(s) ____

Home ____ Contact (if other)_______________

Work ____ Contact (if other) ______________

Cell ____ Contact (if other) ______________

Email address____

ADDRESS:

Street ____

City ____ State________ Zip_____________

How did you hear of our program?____

____

Personality Profile

This information is important for our Therapeutic Riding instructors teach skills using the approaches that will be most effective for each individual.

Please describe personality and strengths:

____

____

____

What are some favorite activities and/or topics?

____

____

What are some fears and/or dislikes?

____

____

____

Our Family's Do's and Don'ts:

____

____

____

Any other special things we should know?

____

____

____

Please list any goals you would like to achieve while riding at Blissful Dreams?

____

____

____

This form was completed by (participant/parent/other):

________________________________ ____________________

Name Date

PARTICIPANT'S CONSENT & RELEASE FORM
CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury while participating in the services of, or while being on the property of Blissful Dreams, I authorize BLISSFUL DREAMS to secure and retain medical treatment and/or transportation if needed. This authorization includes any treatment deemed necessary by a treating health care professional and includes but is not limited to x-ray, surgery, hospitalization, and medication. In addition, I authorize BLISSFUL DREAMS to release my/my child's records to any individual involved in medical treatment and/or necessary transportation.

Participant's Name ____

In case of emergency:

Contact____

Daytime Phone ____________________Evening Phone____________________
_
Secondary Contact____

Daytime Phone __________________Evening Phone_____________________

Primary Physician's Name____

Phone_________________________ Phone_________________________

Health Insurance Name (optional) ____________________________________

Policy #____

Participant's Signature_________________date_______

(or signature of parent/guardian if participant is under age 18)

LIABILITY RELEASE

Under South Carolina Law, 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.

____(Participant's name)
would like to participate in the Blissful Dreams Therapeutic Riding Program. I acknowledge the risks and potential for risks in riding and working with horses. However, I feel that the possible benefits to me/my child/my ward are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs, assigns, executors and/or administrators, waive and release forever all claims for damages against Blissful Dreams, its Board of Directors, Advisory Board, Instructors, Therapists, Aides, volunteers, employees, agents, and representatives of any kind for any and all injuries, damages, claims, demands, causes of actions, law suits, and/or losses I/my child/my ward may sustain while participating in Blissful Dreams's Therapeutic Riding Program.

Participant's Signature_______________________________________date________________

(Or signature of parent/guardian if participant is under age 18)

PHOTO & PUBLICITY RELEASE (Optional):

I hereby consent to and authorize Blissful Dreams to use my/my child's/my ward's name in all audio, visual and written promotional material and to use and/or reproduce any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

Participant's Signature______________________date________

(or signature of parent/guardian if participant is under age 18)

Dear Healthcare Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History and Physician's statement. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

✔	**Condition:**	**Notes:**
	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	
	__Spina Bifida/Chiari II Malformation/Tethered Cord/	
	Hydromyelia	
	__Medical/Psychological	
	__Allergies	
	__Animal Abuse	
	__Physical/Sexual/Emotional Abuse	
	__Blood Pressure Control	

	___Dangerous to self or others	
	___Exacerbations of medical conditions	
	___Fire Setting	
	___Heart Condition	
	___Hemophilia	
	___Medical Instability	
	___Medications– e.g. photosensitivity	
	___Migraines	
	___PVD	
	___Poor Endurance	
	___Other	

PARTICIPANT'S MEDICAL HISTORY
& PHYSICIAN STATEMENT

(To be completed by physician)

Participant's Name________________________________ Date of Birth __________________

Age ___________ Height ___________ Weight ___________

Primary Diagnosis____

Medications____

History of Seizures? Y N If so, what type? __________ date of last seizure?__________

Please list current or past indications/special needs, adaptive equipment, including surgeries:

AREAS	***YES***	***NO***	***COMMENTS***
Visual			
Auditory			
Tactile Sensation			
Speech & Language			
Cognitive/Processing			
Learning & Development			
Psychological/Emotional/			
Behavioral			
Muscular			
Balance			
Orthopedic – Note Scoliosis or			
Hip Subluxation/Dislocation			
Neurologic			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			

Immunity			
Pain			
Allergies			

Other____

To my knowledge, there is no reason this person cannot participate in supervised equestrian activities.

Name & Title (print) ____MD DO NP PA

Practice ____Phone ___________________________

Street ____

City _____________________________________ State_________ Zip_________________

Signature_____________________________________ Date ________________

Certification & Authorization

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that misrepresentation, falsification, or omission of information may disqualify me from further consideration as a student, or may result in my dismissal.
If accepted as a student, I understand that I must abide by all Blissful Dreams policies, rules and regulations.
I authorize Blissful Dreams to investigate all statements contained in this application and to make inquiries of my medical history, as well as other matters as may be necessary for determining my eligibility as a student. I hereby release physicians, employers, schools or individuals from all liability in responding to inquiries relating to my student application.

____

Signature of Student or Guardian Date

If Student cannot legally sign for him or her self, then Legal Guardian must sign below.

____

Legal Guardian of Adult Student Date

Thank You!