Hoofprints to Heal Therapy

Participant/Client Application

Participant Name: _____DOB: _____

Age: _____ Height: _____ Weight: _____

Education (School, grade):_____

Parent/Legal Guardian: _____

Address:_____

Home Phone: _____ Cell Phone: _____

Email: _____

How did you hear about our program(s)?_____

Which program(s) are you interested in participating?

____ Occupational Therapy including Hippotherapy

____ Adaptive/Therapeutic Riding Sessions

Primary diagnosis:_____

Secondary diagnosis:_____

Precautions:_____

Current therapy received, frequency:_____

-Describe abilities/difficulties in the following areas (include assistance/equipment required):

Physical Function (e.g. mobility skills such as walking, transfers, wheelchair use, driving/bus riding, etc.)_____

_____

Psychological/Social Function (e.g., work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears, concerns)

_____

_____

_____

Goals: Why are you applying? What would you like to accomplish?

_____

_____

_____

_____

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Hoofprints to Heal Therapy

HEALTH HISTORY – Please indicate current or past special needs in the following areas:

	Comments
Mobility	
Vision	
Hearing	
Sensation	
Circulation	
Emotional/Mental	
Health	
Behavioral	
Pain	
Bone/Joint	
Muscular	
Thinking/Cognition	
Allergies	
Communication	
Heart	
Breathing	
Digestion	
Elimination	
Shunt Last Revision:	
Seizures Last Seizure:	

Photo Release

(YOU MUST CHECK ONE BELOW) do not leave blank

o I do consent

o I do not consent

Hoofprints to Heal Therapy 1)to use my/my child's photograph in its print, online and video publications; 2) release Hoofprints to Heal Therapy, its employees and any outside parties from all liabilities or claims that I might assert in connection with the above-described activities and 3) waive any right to inspect, approve or receive compensation for any materials or communications, including photographs, videotapes, DVDs, website images or written materials, incorporating photos/images of me/my child

Please sign below confirming your choice:

Date:_____ Signature:_____
(Participant or parent/guardian if under 18)

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Hoofprints to Heal Therapy

Authorization of 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 Hoofprints to Heal Therapy to secure and retain medical treatment and transportation if needed and release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Existing Medical Conditions/Disability/Diagnosis:_____
Allergies:_____
Medications: (include prescription and over-the counter, name, dose, frequency)
_____
Physician's Name:_____ Phone:_____
Preferred Medical Facility:_____
Health Insurance Company: _____
Policy*:_____

Emergency contact:_____ Phone:_____
Relationship to client:_____

Consent Plan

Signing this gives consent to an x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature: _____ Date:_____
(Client, Parent or 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:
_____
_____
Non-Consent Signature: _____Date:_____
(Client, Parent or Guardian):

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Hoofprints to Heal Therapy

Hoofprints to Heal Therapy Client/Rider Guidelines

Riders must wear close-toed shoes (preferably boots) and long pants for riding.

Riders will be required to wear appropriately fitting riding helmets.

No gum or food while mounted/riding.

Riders must have a completed physical form every two years. Riders with seizures and or Down Syndrome must complete a form yearly from their physician.

Sessions will not be cancelled due to rain, but in the case of severe weather such as hurricanes, sessions may be cancelled at the discretion of H2H.

Please give us 24 hours notice for cancellation so we can notify staff and plan accordingly.

After three sessions are missed without appropriate notice, that rider may be asked to change time slots.

Parents must always remain with any siblings and should not allow them to wander unattended. They must watch from outside the fence/gate or remain in their car without interfering with the lesson.

Please sign below saying that you have read the above guidelines and understand them.

Signature: _____ Date: _____

Confidentiality Policy

I understand that information about the participant (Name, goals, progress notes, etc.) will remain confidential unless the appropriate release of information form is signed. Our staff are asked to sign a confidentiality policy regarding participants and what happens in lessons and by signing this form, I also agree to keep information about the other riders confidential and encourage the participant to do the same.
By signing below, you acknowledge that you have read and understand all of Hoofprints to Heal Therapy's policies, including eligibility and discharge of participants, absence policy and confidentiality policy.
Participant Name _____
Participant Signature _____ Date _____
Parent/ Guardian (If participant is under 18)

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Hoofprints to Heal Therapy

GENERAL ACTIVITY RELEASE, ASSUMPTION OF RISK and WAIVER OF LIABILITY AGREEMENT

This document waives important legal rights. Read it carefully before signing.

I AGREE for my child and or myself participation in Hoofprints to Heal's activity of the following:

I AGREE that I choose to participate voluntarily in Hoofprints to Heal's activities as a client, rider, handler, assistant, therapist or spectator. I am fully aware and acknowledge that equine activities and Hoofprints to Heal's activities involve inherent dangerous risks of accident, loss, and serious bodily injury including, but not limited to, broken bones, head injuries, trauma, pain, suffering or death ("harm"). I fully understand that this release covers, but is not limited to, inherent risks of an equine activity, which mean a danger, or condition that is an integral part of an equine activity, including but not limited to, any of the following:

- ❖ The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;
- ❖ The unpredictability of an equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals;
- ❖ Hazards, including, but not limited to, surface or subsurface conditions;
- ❖ A collision with another equine, another animal, a person, or an object;
- ❖ The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant.

I AGREE that I/my child would like to participate in the Hoofprints to Heal's program. I acknowledge the risks and potential risks; however, I feel that the possible benefits to me/my child are greater than the risk assumed. I hereby, intending to be legally bound for myself, waive and release forever all claims for damages against Hoofprints to Heal, its board of directors, instructors, therapists, aides, volunteers, employees, for any and all injuries and/or losses I may sustain while participating in the Hoofprints to Heal program including activities occurring outside of the scope of the program itself, including, but not limited to transportation, care giving, horse exercising etc.

By signing below, I ACKNOWLEDGE that I enter this release after having read the same and place my signature hereto of my own free voluntary act and deed. By signing below, I represent to Hoofprints to Heal that I fully understand its contents, that I do not need any further explanation, and I waive any further explanation.

I AGREE to assume all risks of harm to me and or my child, and specifically agree to the FLORIDA LIABILITY LAW regarding equine/farm/agritourism/animal activity liability: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in an equine activity resulting from an inherent risk of equine activity.

Participant Name _____

Participant Signature _____ Date _____
Parent/ Guardian (If participant is under 18):

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Hoofprints to Heal Therapy

Participant's Consent for Release of Information

I hereby authorize:_____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to:_____
(center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

o Medical history

o Occupational therapy evaluation, assessment and program plan

o Mental health diagnosis and treatment plan

o Classroom Individual Education Plan (IEP)

o Psychosocial evaluation, assessment and program plan

o Cognitive-behavioral management plan

o Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date:_____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

Please send materials to: _____

Please send materials to: _____

Please send materials to: _____

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Hoofprints to Heal Therapy

Fee Agreement

Hoofprints to Heal Therapy, LLC appreciates fees to be paid by check or cash after each session is completed. Invoices may be generated upon client request. A 24 hour cancellation notice for appointments is appreciated.

Fees - Self Pay (cash, check or PayPal) or Gardiner Scholarship:	
Occupational Therapy Evaluation	$150
OT Treatment Session including Hippotherapy	$115
Therapeutic Riding/Adaptive Riding	$90

By signing below, I agree to the above terms and fees set for services.

_____
Patient's name

_____
Gardiner Scholarship Number

_____
Print name of responsible party

_____ Date:_____
Signature of responsible party

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Hoofprints to Heal Therapy

INFORMATION FOR PHYSICIAN

Date: _____

Dear Health Care Provider:

Your patient _____
(participant's name)

is interested in participating in supervised equine 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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures

Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
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 equine-assisted activities, please feel free to contact the center at the address/phone indicated above.
Sincerely,

Name Center Name Phone Number

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Hoofprints to Heal Therapy

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
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:*
Neurologic Symptoms of Atlantoaxial Instability: Present Absent

Please circle current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Hoofprints to Heal Therapy for ongoing evaluation to determine eligibility for participation. I have read the attached precautions and contraindications.
Name/Title: _____ MD DO NP PA Other
Signature: _____ Date:_____
Address:_____
Phone: ( ) License/UPIN Number: _____
Physician Statement Continues

Hoofprints to Heal Therapy

Physician Statement Continued

Participants with Down syndrome

Does the individual have an annual medical clearance from a licensed physician that includes a neurological exam that specifically denies any symptoms consistent with Atlantoaxial instability?
Yes No

Has there been a neurological exam that specifically denies any symptoms consistent with Atlantoaxial instability (AAI) in the last year?
Yes No

By signing below, I confirm that the participant has revealed no signs of AAI or decrease in neurological function. To my knowledge there is no reason why this person cannot participate in supervised equestrian activities.

Licensed Medical Examiner's Signature: _____Date of EXAM:_____
Physician's Name (please print): _____Phone:_____
Address:_____

***Participants with Seizure Disorders**

PATH (Professional Association of Therapeutic Horsemanship Intl) recommends the following information for PATH operating Centers for riders with seizure disorders.

Would you consider _____'s seizures to be:

Completely controlled Very well controlled Not controlled by medication

Note that the following are contraindications to riding:

• Recent seizure activity accompanied by strong, uncontrollable motor activity or atonic or drop attack seizures due to their sudden and complete loss of postural muscle tone
• A change of frequency or type of seizure until the condition is evaluated
• Inability to manage a participant during an emergency dismount should a seizure occur.

Type of seizure:_____

Typical motor activity during seizure:_____

_____

Description of clients' behavior during seizure state:_____

_____

Specific directions as to what to do if a seizure should occur at Hoofprints to Heal Therapy:_____

_____

Physicians signature:_____Date:_____

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