Hoofbeats For Hope

Changing Lives...One Hoofbeat At A Time!

PATH INTERNATIONAL

Rider Packet

When this packet is complete (including physican's signature)

Fax entire packet to 405-321-7571

or mail to

Hoofbeats For Hope

P.O. Box 270

Norman, OK. 73070

Updated: December 23, 2015

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Authorization for Emergency Medical Treatment Form

[ ] Participant [ ] Staff [ ] Volunteer

Name:_____ **DOB:**_____ **Phone:**_____

Address:_____

Physician's Name:_____**Preferred Medical Facility:**_____

Health Insurance Company:_____**Preferred Medical Facility:**_____

Allergies to medications:_____

Current medications:_____

In the event of an emergency, contact:

Name:_____ **Relation:**_____ **Phone:**_____

Name:_____**Relation:**_____ **Phone:**_____

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 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 (Signed in presence of center staff)

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 (Signed in presence of center staff)

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Participant Medical History & Physician Statement

Part 1

Date:_____

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete 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 the attached form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. 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 (ie. RA, MS)
Fire Settings
Hemophilia
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 below.

Sincerely,

Susan Patten (Instructor) 405-650-6175
Carrie Hare (Instructor) 405-615-7191

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Participant Medical History & Physician Statement

Part 2

Partipant:_____ 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: AtlantoDens Interval X-rays, date:_____ Result + -

Neurologic Symptoms of AtlantoAxial Instability:_____

Please indicate current or past special needs 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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in Equine assisted activities. I understand that HOOFBEATS FOR HOPE will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to HOOFBEATS FOR HOPE for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____

Signature:_____ Date:_____

Address:_____

Phone: _____ License/UPIN Number:_____

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RIDER CONTACT INFORMATION FORM

Name of Rider:_____

Mother/legal guardian:

Name:_____ Address:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

Father/legal guardian:

Name:_____ Address:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

Caregiver or any additional persons who are authorized to bring client to therapy:

1. Name:_____ Relationship to Rider:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

2. Name:_____ Relationship to Rider:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

3. Name:_____ Relationship to Rider:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Email Address:_____

PHOTO RELEASE FORM

I ☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by HOOFBEATS FOR HOPE of any and all photographs and any other audio/visual material taken of me, or my child, for promotional material, social media, educational activities, social media distribution, and exhibitions or for any other use for the benefit of the program.

_____ _____

Signature of Participant **Date**

_____

Print Name of Participant

_____ _____

Signature of Parent of Guardian **Date**

(If participant is under 18 or unable to sign)

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Release and Hold Harmless Agreement

I, _____ (Name of Participant), have the opportunity to participate in Hoofbeats for Hope Ltd., Co. Therapeutic Riding program at Hoofbeats for Hope Ltd., Co. Therapeutic Riding Center.

I understand that participating in equine activities, as a participant, rider, volunteer, student, spectator or staff, exposes me to a risk of property damage, personal injury or death. I understand that my choice of participating in equine activities is voluntary on my part, and I affirm my desire to participate in the program set out above. I agree to assume full responsibility for my safety and the safety of my property while I am in the arena or barn, in transit to and from the arena and at all other times. I understand that I may sometimes participate in various activities, some of which may include an element of risk.

In consideration of being allowed to participate in the above mentioned activity, I, the undersigned, and my Parent/Guardian, if applicable, do hereby release, indemnify, and hold harmless Hoofbeats for Hope, Ltd., Co. Therapeutic Riding Center, all the Center's officers, agents, employees and volunteers, any allied health, mental health professionals and any other professionals volunteering and/or contracting with Hoofbeats for Hope Ltd., Co. Therapeutic Riding Center or any other equine activity sponsor as well as other participants and spectators from any and all liability claims, demands, and actions whatsoever arising out of or related to any loss, damage, or injury, including death, which may be sustained by me or to any property belonging to me. The terms hereof shall also serve as a release and assumption of risk for my heirs, executor and administrator, and for all members of my family, and may be pleaded as a bar to litigation. Jurisdiction of this matter and venue shall lie exclusively in Slaughterville, Cleveland County, Oklahoma.

WARNING

TITLE 76 O.S.A. SEC. 50.3 (THE OKLAHOMA LIVESTOCK ACTIVITIES LIABILITY LIMITATION ACT) STATES:

..... a livestock activity sponsor, a participant, or a livestock professional acting in good faith and pursuant to the standards of the livestock industry shall not be liable for injuries to any person engaged in livestock activities when such injuries result from the inherent risks of livestock activities.

I am 18 years of age or above (or my Parent/Guardian is also a signatory herein) and have read this Release and Hold Harmless Agreement and understand and voluntarily accept the terms.

_____	_____	_____
Signature of Participant	Date	Print Name of Participant

PARENT/GUARDIAN

(This section must be completed if participant is under 18 or legally incapacitated)

By signing herein, I acknowledge that I have read, understand and voluntarily agree to accept the terms of the above Release and Hold Harmless Agreement with respect to the above named Participant.

_____	_____	_____
Signature of Parent/Guardian of Participant	Date	Printed Name of Parent/Guardian

Hoofbeats for Hope Cancellation Policy

Volunteers are the backbone of our program and we must be considerate of their time. We strive to provide riding opportunities for as many riders as possible. If you know you will be absent, we are able to offer that lesson time to another rider or notify volunteers that they will not be needed.

For these reasons, if you will not be able to attend your lesson, we request that you give us 24 hours notice prior to your scheduled lesson time. If 24 hours notice is not received, a lesson fee will be charged. Please call or text Susan 405/650-6175 or Carrie 405/615-7191

We understand that there will be times that it is impossible to give us 24 hours notice i.e.; sudden illness, car trouble, family emergency, etc. You will have three "freebies" per calendar year to be used to cancel without incurring a lesson fee.

We appreciate your cooperation with this new policy and if you have questions or concerns, please speak with us.

(Please keep this copy for reference)

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(Please initial this page and return to us. We have included a copy for you to keep)