Participant's Application & Health History

STEP
SUNCOAST THERAPEUTIC EQUINE PARTNERS

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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

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

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency) _____

_____

_____

_____

_____

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

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

PSYCHOSOCIAL FUNCTION (e.g., 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?) _____

_____

_____

_____

_____

Signature: _____ Date: _____

PHOTO RELEASE

I ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by Suncoast Therapeutic Equine Partners, Inc. (STEP) 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

Authorization for Emergency Medical Treatment

CONSENT PLAN
In the event emergency medical aid/treatment is required due to illness or injury while participating in the Suncoast Therapeutic Equine Partners, Inc. (STEP) program, I authorize STEP to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "lifesaving" by the physician. In addition, I authorized STEP to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date _____ Participant's name (print) _____DOB_____

Home phone #_____ Street Address_____

City_____State_____ Zip_____

In case of emergency, contact:

Name_____ Relationship: _____Phone Number(s)_____

Physician's name _____Phone Number_____

Preferred medical facility_____

Allergies to Medications_____

Current Medications: _____

Health insurance company _____Policy #_____

Consent Authorized Signature _____Date: _____
(Participant OR Parent / Legal Guardian if under 18)

NON-CONSENT PLAN
I do not give my consent for emergency medical treatment in the case of illness or injury while participating in the STEP program. In the event emergency treatment aid is required, I wish the following procedures to take place: (list procedures)
_____

Participant's name (print)_____Date_____

Non-Consent Authorized Signature _____
(Participant OR Parent / Legal Guardian if under 18)

Updated: 8/21/2025

Confidentiality Policy

Suncoast Therapeutic Equine Partners, Inc. (STEP) recognizes the right of participants and their families to have privacy and control over any information about them that might be personal or sensitive.

Those bound by the directives of this policy are all persons in any way connected with STEP, including but not limited to: full and part-time staff, volunteers, board members, temporary employees, independent contractors and instructors. Any persons violating these policies will be subject to penalties ranging from reprimand to alteration of job responsibilities to termination to legal action.

Except as deemed necessary by the Board of Directors, information considered to be confidential includes all medical, familial, social, referral, personal and financial concerns regarding a participant and family. Such information is considered confidential regardless of how it is obtained, whether directly from the participant or family, STEP staff, volunteers or others associated with STEP, or inadvertently from other sources such as, but not limited to, a chart, computer screen or overheard conversation.

Consent to disclose information to outside individuals or agencies, including photographs and videotapes, should be obtained in writing from the proper legal representative. For most children under the age of 18, this would be the parent or legal guardian. Adults aged 18 and over with developmental disabilities are presumed competent to give consent unless they have specifically been found incompetent in a court of law. In such case, a substitute decision-maker would be assigned, and any consent must be obtained from the decision-maker.

Updated: 8/21/2025

Code of Conduct Policy

Respect for Others:

I will respect the rights, dignity and worth of other STEP participants, volunteers, instructors, staff, friends, family members and spectators.

I will treat everyone equally regardless of sex, ethnic origin, religion or ability.

I will display control, respect, dignity and professionalism to all involved including participants, volunteers, instructors, staff, friends, family members and spectators.

Responsibility for My Actions:

I will always dress and act in a professional manner that will be a credit to STEP. I will not use profanity or insult or taunt others or engage in other forms of poor behavior. I will practice good sportsmanship.

I will not engage in any type of inappropriate behavior, sexual activity and/or verbal or physical abuse with other participants, volunteers, instructors, staff, friends, family members or spectators.

I will respect the property of STEP. I will respect every horse and will not engage in physically abusive behavior toward any of them.

I will obey all posted STEP rules of the farm.

I have read and understand the STEP rules of the farm.

I have read and understand the STEP Confidentiality Policy and Code of Conduct Policy and agree to observe these policies.

Print Name: _____

Signature: _____

Date: _____

Updated: 8/21/2025

SUNCOAST THERAPEUTIC EQUINE PARTNERS, INC.

Premises: 1615 Verna Road, Sarasota, FL 34240

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT

By signing this Release and Waiver of Liability, Assumption of Risk and Indemnification Agreement ("Agreement"), I represent that I have read and understand the Agreement. Suncoast Therapeutic Equine Partners, Inc. is referred to herein as STEP, and includes the officers, directors, volunteers, staff, instructors and agents of STEP. "Equine" means a horse, mini horse, pony, mule, donkey or hinny. "Equine Activities" includes, but is not limited to riding, assisting in the care of or interacting with an Equine, either on or off the Equine at the premises of STEP or other locations and maintaining or repairing the facilities of STEP at its premises. I understand that these Equine Activities involve the risk of serious bodily injury or death.

In consideration of my or my child's/legal ward's participation and/or assistance and/or volunteering in the Equine Activities of STEP, I ("Participant" or "Volunteer") on my own behalf, or through my legal guardian, agree and consent to the following.

RELEASE AND WAIVER OF LIABILITY

I hereby release STEP and its officers, directors, volunteers, staff, instructors and agents from any and all claims, liabilities damages and losses, including any claim for personal injury, death or property damage sustained by me while participating in Equine Activities, including claims for liability caused in whole or in part by the negligent acts or omissions of STEP or STEP's failure to exercise reasonable care in the conduct of Equine Activities. I agree that I will not hold STEP responsible for any such injuries or death and agree not to sue STEP for such injuries.

ASSUMPTION OF RISK

I acknowledge that Equines and Equine Activities are dangerous and that my participation in such activities involves the risk of personal injury or death or property damage. I voluntarily assume all such risks, dangers and hazards inherent in such Equine Activities.

INDEMNIFICATION

I agree to indemnify, defend and hold harmless STEP and any released parties for any claims for personal injury, death or damage to property arising out of or relating to acts of the undersigned while participating in Equine Activities at STEP's premises or other locations.

DAMAGES

I agree to be responsible for all damages caused by me, my animals, invited minor children or anyone with me while on STEP's premises, property or grounds or while participating and/or volunteering in any Equine Activities.

ENFORCEMENT

I agree that this Agreement shall be governed by the laws of the State of Florida and that venue for any legal proceedings related to the Agreement shall be in Sarasota County, Florida. I agree that if I breach the Agreement, I will pay the attorney's fees and court costs incurred by STEP in the enforcement of the Agreement.

WARNING: Under Florida law, an equine activity sponsor or equine professional is not liable for injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities. Section 773.04 Florida Statutes.

Name of Participant/Volunteer_____

Signature (if 18 or older) _____Date_____

Participant/Volunteer Address_____

Phone_____Email_____

I hereby certify that I am authorized to sign this Agreement on behalf of the Participant/Volunteer.

Parent/Guardian (Print)_____

Signature)_____Date_____

Address_____+_____Phone_____

Email_____

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/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 Cord/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
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 services, please feel free to contact Suncoast Therapeutic Equine Partners, Inc.

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

	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 services. I understand that Suncoast Therapeutic Equine Partners, Inc. (STEP) will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to STEP for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

STEP
SUNCOAST THERAPEUTIC EQUINE PARTNERS

STEP RULES

These rules are designed to ensure the safety of all humans and equines at STEP

1. No abusive, threatening, or violent behavior will be tolerated on the premises.
2. Illegal drug and alcohol use are prohibited.
3. NO smoking in or around the stable grounds. Smoking is permitted only in the privacy of your vehicle in the parking lot. *Please do not leave your cigarette butts in the grass or on the premises!*
4. All visits to the STEP facility must be supervised by a staff member.
5. During lesson times, all participants and other children must be supervised by their Parents or Care Providers until they are attended to by STEP Staff. No running or screaming is allowed in the barn or around the horses.
6. Participants are not allowed to play on the ramp, mounting blocks, gates and fences.
7. Parents, Care Providers, Siblings and Friends must remain in the designated waiting areas during their participant's lesson unless accompanied or approved by staff.
8. If a parent or guardian must leave premises during lessons, they **must** notify the instructor in charge and leave a cell phone number for immediate contact in case of emergency.
9. The mounting ramp and mounting block are only to be used for mounting and dismounting participants. Only instructors and trained staff will assist with the mounting and dismounting of participants.
10. Please do not handle, feed or pet horses in their stalls or in their paddocks unless supervised or approved by a staff member.
11. No one may enter a stall, paddock or arena containing horses unless accompanied or approved by a staff member.
12. No one may ride a horse unless supervised by a STEP Instructor. All program participants in adaptive riding and EAL must have an annually completed Application and Release packet on file.
13. All participants must wear an ASTM-approved helmet during mounted and unmounted lessons and use safety stirrups. We recommend that all riders wear hard-soled shoes with heels.
14. All accidents, injuries or hazardous conditions must be reported to a staff member immediately. In case of emergency, please follow the directions given by the Instructor(s) and Staff in charge.
15. No pets allowed on property except leashed service animals kept away from horses and activities.
16. **Please obey all signage.**

WARNING: ***Under Florida Law, an equine activity sponsor or 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.***

I have read and understand all of the rules above and agree to abide by them.

_____ _____

Signature **Date**

Updated: 8/21/2025