PARTICIPANT APPLICATION/ REGISTRATION - 2024

BLUFF & RIDGE
Equine Assisted Therapies, INC

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
Member

Name of Rider_____Birthdate_____ Height _____Weight _____

Address _____Home Phone _____

City, State, Zip _____ Cell Phone _____

E-mail _____

Is Rider a member or veteran of the Armed Forces, Police or Fire Service? ☐Yes ☐ No

IF UNDER 18 YEARS OF AGE, COMPLETE THE FOLLOWING:

Name of School _____

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City/State/Zip: _____City/State/Zip: _____

Phone _____ Phone _____

Email _____ Email _____

Employer _____ Employer _____

EMERGENCY CONTACT (other than parent or guardian)

Name _____ Phone _____

Relationship _____ Cell _____

Is Rider currently enrolled in:

Physical Therapy: ☐ Yes ☐ No

Occupational Therapy: ☐ Yes ☐ No

Speech Therapy: ☐ Yes ☐ No

Behavioral/Psychological Therapy: ☐ Yes ☐ No

Explain therapy involvement:

Mailing Address: Bluff & Ridge Equine Assisted Therapies, Inc. (BREATHE)
30662 Moccasin Avenue; Kendall, WI 54638

HOW DID YOU HEAR ABOUT BLUFF & RIDGW EQUINE-ASSISTED

THERAPIES, INC.? ☐Newspaper ☐ Website ☐ Facebook ☐ Radio/TV ☐ Poster

☐ A Volunteer ☐ Another Organization ☐ Other

HAS RIDER EVER RIDDEN A HORSE BEFORE? ☐YES ☐ NO

IS RIDER WILLING TO ATTEND EVERY CLASS? ☐ YES ☐ NO

IS THERE A PARENT, GUARDIAN, SIBLING, OR OTHER PERSON INTERESTED IN HELPING DURING THE RIDER'S CLASS TIME? IF SO, PROVIDE THEIR NAME

IS THERE ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD BE HELPFUL TO BLUFF & RIDGE EQUINE-ASSISTED THERAPIES, INC.?

BLUFF & RIDGE
EQUINE-ASSISTED THERAPIES, INC.

RIDERS MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Rider Name: _____DOB: _____
Address: _____ City/State/Zip: _____
Required to match to a horse: **Height: _____Weight: _____**
Body shape: ☐ Apple ☐ Pear ☐ Stringbean
Primary Diagnosis: _____ Date of Onset: _____
Secondary Diagnosis: _____ Date of Onset: _____
Shunt Present: ☐Y ☐ N Date of Last Revision: _____
Mobility: Independent Ambulation ☐ Y ☐ N Assisted Ambulation ☐ Y ☐ N
Wheelchair ☐ Y ☐ N Braces/Assistive Devices ☐ Y ☐ N
***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 system/areas, including surgeries

	Yes	No	Comments
Auditory	☐	☐	
Visual	☐	☐	
Tactile Sensation	☐	☐	
Speech	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Integumentary System	☐	☐	
Immunity	☐	☐	
Pulmonary	☐	☐	
Neurologic	☐	☐	
Muscular	☐	☐	
Balance	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning Disability	☐	☐	
Cognitive	☐	☐	
Emotional/Psychological	☐	☐	
Pain	☐	☐	
Other	☐	☐	

Additional Physician Instructions noted on reverse side of this form: ☐YES ☐ NO

Physician's Statement:
Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that Bluff & Ridge Equine-Assisted Therapies, Inc., will weigh the medical information given against the existing precautions and determine eligibility for participation.

Name/Title _____ ☐MD ☐DO ☐NP ☐PA ☐Other
Signature: _____ Date _____
Address: _____ City/State/Zip _____
Phone: _____ License/UPIN Number _____

MEDICATIONS: (Include prescription and over the counter. Provide medication name, dose, and frequency)

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed).
PHYSICAL FUNCTION: (i.e. mobility skills such as transfers, walking, wheelchair use, driving, bus riding)

PSYCHO/SOCIAL FUNCTION: (i.e. Work/school including grade completed, leisure interests, relationship family structure, support systems, companion animals, fears, concerns, etc.)

GOALS: (i.e. Why are you applying for participation? What would you like to accomplish?)

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
☐Spinal Fusion
☐Spinal Instabilities/Abnormalities
☐Atlantoaxial Instabilities
☐Scoliosis
☐Kyphosis
☐Lordosis
☐Hip Subluxation and Dislocation
☐Osteoporosis
☐Pathologic Fractures
☐Coxas Arthrosis
☐Heterotopic Ossification
☐Osteogenesis Imperfecta
☐Cranial Deficits
☐Spinal Orthoses
☐Internal Spinal Stabilization Devices

Medical/Surgical
☐Allergies
☐Cancer
☐Poor Endurance
☐Recent Surgery
☐Diabetes
☐Peripheral Vascular Disease
☐Varicose Veins
☐Hemophilia
☐Hypertension
☐Serious Heart Condition
☐Stroke (Cerebro-vascular Accident)

Neurologic
☐Hydrocephalus/shunt
☐Spina Bifida
☐Tethered Cord
☐Chiari II Malformation
☐Hydromyelia
☐Paralysis due to Spinal Cord Injury
☐Seizure Disorders

Secondary Concerns
☐Behavior problems
☐Age less than two years
☐Age two-four years
☐Acute exacerbation of chronic disorder
☐Indwelling catheter

BLUFF & RIDGE EQUINE-ASSISTED THERAPIES, INC.

LIABILITY, PHOTO, MEDICAL CONSENT RELEASE
NEEDS TO BE COMPLETED FOR ALL RIDERS, VOLUNTEERS and STAFF
PARENT/GUARDIAND SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18

LIBILITY RELEASE

I/ my child/ my ward would like to participate in the Bluff & Ridge Equine-Assisted Therapies, Inc. (BREATHE) Program as a rider, volunteer, or staff person. I acknowledge the risk and hazardous nature of horse activities and horseback riding. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors or administrators, waive and release forever all claims for damages against Bluff & Ridge Equine-Assisted Therapies, Inc., its Board of Directors, instructors, therapists, aides, volunteers, horse owners and/or employees for any and all injuries and/or losses that I/ my child/ my ward may sustain while traveling to or from, or participating in any BREATHE activities.

Signature: _____Date: _____

Parent or Guardian: _____ Date: _____

Wisconsin State Statutes Sec. 95.481

Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack in the instruction of a person in the riding or driving of equine or in being a passenger upon an equine is not liable for injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1) (e) of the Wisconsin State Statutes.

PHOTO RELEASE

I ☐ DO ☐DO NOT consent to and authorize the use and reproduction by Bluff & Ridge Equine-Assisted Therapies, Inc., of all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or another use for the benefit of the program.

Signature: _____Date: _____

Parent or Guardian: _____ Date:_____

MEDICAL TREATMENT CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or any other use for benefit of the agency.

I authorize Bluff & Ridge Equine-Assisted Therapies, Inc. to:

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 emergency medical treatment. This authorization includes x-ray, hospitalization, medication, 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.

Consent Signature _____Date _____

MEDICAL TREATMENT 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. Parent or legal guardian will always remain on site during equine assisted activities. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Non-Consent Signature _____Date _____

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