Bluff & Ridge Equine Assisted Therapies, INC

PARTICIPANT APPLICATION/ REGISTRATION

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.
23797 County Hwy CM; Tomah, WI 54660

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.

BLUFF & RIDGE Equine Assisted Therapies, INC

PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International Member

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	☐	☐	Click or tap here to enter text.
Visual	☐	☐	Click or tap here to enter text.
Tactile Sensation	☐	☐	Click or tap here to enter text.
Speech	☐	☐	Click or tap here to enter text.
Cardiac	☐	☐	Click or tap here to enter text.
Circulatory	☐	☐	Click or tap here to enter text.
Integumentary System	☐	☐	Click or tap here to enter text.
Immunity	☐	☐	Click or tap here to enter text.
Pulmonary	☐	☐	Click or tap here to enter text.
Neurologic	☐	☐	Click or tap here to enter text.
Muscular	☐	☐	Click or tap here to enter text.
Balance	☐	☐	Click or tap here to enter text.
Orthopedic	☐	☐	Click or tap here to enter text.
Allergies	☐	☐	Click or tap here to enter text.
Learning Disability	☐	☐	Click or tap here to enter text.
Cognitive	☐	☐	Click or tap here to enter text.
Emotional/Psychological	☐	☐	Click or tap here to enter text.
Pain	☐	☐	Click or tap here to enter text.
Other	☐	☐	Click or tap here to enter text.

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)
Click or tap here to enter text.

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)
Click or tap here to enter text.

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

GOALS: (i.e. Why are you applying for participation? What would you like to accomplish?)
Click or tap here to enter text.

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: Click or tap to enter a 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 ________________________