Trails of Purpose Participant Information

Participant Name:____ DOB:______________
Diagnosis: ____ Onset: _____________
Age: _______ Height: _______ Weight: ________ Gender: M F
Address: ____
City: ___________________________ State: __________ ZIP: ______________
Telephone: __________________(h) ___________________(w) ______________(cell)
Employer/Duty Station____
Address: ____
Telephone: __________________(h) ____________________(w) ______________(cell)
Email: ______________________________________
Referral Source: ______________________________ Telephone: ________________________
How did you hear about Trails of Purpose? _________________

Participant Health History

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

Circle One Y (Yes), N (No)	Comment
Vision: Y N	
Hearing: Y N	
Sensation: Y N	
Communication: Y N	
Heart: Y N	
Breathing: Y N	
Digestion: Y N	
Elimination: Y N	
Circulation: Y N	

Emotional/Mental Health: Y N	
Behavioral: Y N	
Pain Bone/Joint: Y N	
Muscular: Y N	
Thinking/Cognition: Y N	
Allergies: Y N	
Fear/aversion to animals: Y N	

Required Medications (include prescription, over-the-counter; name, dose and frequency, side effects encountered): ____

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

Physical Function (mobility skills such as transfers, walking, wheelchair use, driving/bus riding):
____
____

Psycho/Social Function (work/school including grade completed, leisure interests, relationship-family structure, support system, companion animals, fears/concerns, etc):
____
____

Goals (Why are you applying to participate? What would you like to accomplish?):
____
____

Trails of Purpose

Participant:________________________

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

MEDICAL/PSYCHOLOGICAL Allergies Animal Abuse Cardiac Condition Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to Self or Others Exacerbations of Medical Conditions Fire Settings Hemophilia Medical Instability Migraines PVD Respiratory Compromise Recent Surgeries Substance Abuse Thought Control Disorders Weight Control Disorders

NEUROLOGIC Hydrocephalus/shunt Seizure Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

OTHER Indwelling Catheters/Medical Equipment/ Medications:

Thank you very much for your assistance. Should 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,

Kayla Arestivo,
Executive Director

Trails of Purpose
757-655-5566
Trailsofpurpose@gmail.com

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant Name_________________________ 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 Y N
Devices: ____

Please indicate current or past special needs in the following systems/areas, including surgeries:

Circle One Y (Yes), N (No)	Comment
Auditory: Y N	
Visual: Y N	
Tactile Sensation: Y N	
Speech: Y N	
Cardiac: Y N	
Circulatory: Y N	
Integumentary/Skin: Y N	
Immunity: Y N Comments	
Pulmonary: Y N	
Neurologic: Y N	
Muscular: Y N	
Balance: Y N	
Orthopedic: Y N	
Allergies: Y N	

Learning Disability: Y N	
Cognitive: Y N	
Pain: Y N	
Emotional/Psychological: Y N	
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 Trails of Purpose will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Trails of Purpose for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA

Other Signature: ____
Date: ______________________

Address: ____
Phone: (   )_____-________
License/UPIN Number: _____________________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid treatment is required due to illness or injury during the course of participating with Trails of Purpose, or while being on said premises of the organization, I hereby authorize Trails of Purpose and/or its representatives to:

1. Obtain medical treatment and/or transportation if needed; and
2. Release client records upon request to the authorized agency or its representative involved in the medical emergency treatment Participant Name:____________________________

Telephone:
Address:____

In the event that I am unconscious, please contact:
Name:____
Telephone: ____
Relationship: ____
Physician's Name:_____________________________________
Telephone:____
Medical Facility: ______________________________________
Telephone: ____
Health Insurance Company: ____________________________
Telephone: ____
In an effort to provide the best care possible, please indicate below:
I am allergic to the following
medications:____
I have the following ongoing medical conditions: ____
Name:______________________________
Date:____/_____/_______

NON-CONSENT FOR MEDICAL TREATMENT I DO NOT give consent for emergency medical treatment for myself in the case of illness or injury during the course of participating in the lesson program or while on the premises of the Trails of Purpose. In the event emergency treatment/aid is required, I wish the following procedure to take place:
Date:____/____/________
Participant Printed Name:____
Address: ____
Phone: (   ) _____-________

PARTICIPANT RELEASE AGREEMENT

I, ______________________________________the undersigned adult participant, for and in consideration of the agreement of the Trails of Purpose, to provide equine-assisted activities for myself, do hereby forever release, acquit, discharge, and hold harmless Trails of Purpose, its officers, trustees, agents, employees, representatives, successors, and assigns, for all manner of claims, demands, and damages of every kind and nature whatsoever, which I may now or in the future have against Trails of Purpose, its officers, trustees, agents, employees, representatives, successors, or assigns on account of any personal injuries, physical or mental condition, known or unknown, to myself, and the treatment thereof, as a result of, or in any way growing out of the acts of the Trails of Purpose, its officers, trustees, agents, employees, representatives, successors, or assigns, including but not limited to their negligence or gross negligence, in rendering the services above described or in any way incidental thereto. In accordance with Act 3.1-796.132 of the Code of Virginia, notice is hereby given on the intrinsic dangers of equine activities, including (i) the propensity of an equine to behave in dangerous ways which may result in injury to the participant; (ii) the inability to predict an equine's reaction to sound, movements, objects, persons, or animals; and (iii) hazards of surface or subsurface conditions. Date:_____/___/______

PARTICIPATION POLICY AND PROCEDURES

1. The purpose of Equine Assisted Activities/Learning is to foster positive self-awareness by all participants and allow for outdoor recreational opportunities for U.S. Veterans.
2. Every attempt will be made, each session,to accommodate each Veteran into classes. Discretion is up to the instructors to determine if cancelation of the class is appropriate based on weather, or other external circumstances.
3. The Trails of Purpose program is free to all Veterans.
5. Participants are encouraged to be ready for their lessons and arrive on time.
6. Lessons will be held year round in accommodating weather. Weather that is inclement will result in class cancelation and classes will resume the following week (weather permitting).

Name: ___________________________Date:_____/____/_______

PHOTOGRAPH AND MEDIA RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grants to Trails of Purpose, permission to take or have taken still and/or moving photographs and films, including, but not limited to, television pictures of myself _____________________, and consents and authorizes Trails of Purpose and its affiliates, advertising agencies, news media and any other persons interested in Trails of Purpose, and its work, to use and reproduce the photographs, films, and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing, newspapers, television media, brochures, pamphlets, instructional, clinical and/or research materials and books. With respect to the foregoing matters, no inducements or promises have been made to me to secure my signature(s) to this release other than the intention of Trails of Purpose, to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding the program and its mission.

Dated: ______/____/__________

Name: _____________________

NON-CONSENT FOR PHOTOGRAPH

For reasons that I am not obligated to disclose, I DO NOT GIVE CONSENT for photographs, either still or moving, or any television or news media, to be taken of myself by Trails of Purpose or any persons working on behalf of said program.

Dated: ______/____/____________

Name: ______________________