SHARE Therapeutic Riding Program

5200 McGill Rd
Anderson, SC 29626
AwesomeRiding@gmail.com
(910) 538-5575

Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

DOB: _____Age:_____ Height: _____Weight: _____Gender: M _____F _____

Address: _____City:_____State:_____Zip:_____

Email Address: _____

Phone: _____Alternate phone (cell or work)_____

School/Employer: _____

Parent/legal Guardian/Caregivers: _____

Address (if different from above): _____City:_____State:_____Zip:_____

Phone: _____Alternate phone (cell or work)_____Email:_____

Reference: _____ Phone: _____

How did you hear about the program?_____

Medications (including over-the-counter and prescription, with NAME, DOSE, 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, 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?)

_____

_____

_____

PHOTO RELEASE

I _____Do

_____ Do Not

Consent to and authorize the use and reproduction by SHARE of any and all photographs and 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:_____

Participant/Legal Guardian/Parent

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Participant's Consent for Release of Information

I hereby authorize the release of information from the records of
_____ DOB: _____
(participant's name)

The information is to be released to SHARE Therapeutic Riding Program for the purpose of developing an equine activity program for the above named participant.
The information to be released is indicated below.

- □ Medical History
- □ Physical therapy evaluation, assessment and program plan
- □ Occupational therapy evaluation, assessment and program plan
- □ Individual Habilitation Plan (I.H.P.)
- □ Classroom Individual Education Plan (I.E.P.)
- □ Psychological evaluation, assessment and program plan
- □ Cognitive-behavioral management plan
- □ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date:_____

Print Name: _____

Relationship to Participant: _____

Please bring or mail to:
Lisa Hartman
5200 McGill Rd
Anderson, SC 29626

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This is an update for your participant's physician.
Attach a copy of the Participant's Medical History and Physician's Statement.

Date:_____

Dear Health Care Provider:
Your patient
_____
is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History one-sided 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 Coxa Arthrosis Cranial Deficits Heterotopic Ossification/Myositis Ossificans Joint Subluxation/dislocation Osteoporosis Pathologic Fractures Spinal Fusion/Fixation Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Medical/Psychological
Allergies Animal Abuse Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to self or others Exacerbations of medical conditions Fire Setting Heart Condition Hemophilia Medical Instability Medications – e.g. photosensitivity Migraines PVD Poor Endurance Respiratory Compromise Recent Surgeries Skin Breakdown 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 activities, please contact me at SHARE

Sincerely,
Lisa Hartman, Program Director
SHARE Therapeutic Riding Program
AWESOMEriding@gmail.com
910-538-5575

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Participant's Medical History & Physician's Statement

Participant:_____DOB:_____Height:_____Weight: _____

Address: _____City: _____State:___ Zip: _____

Diagnosis: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____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 Atlanto Axial Instability: _____

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

	YES	NO	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Neurologic Given the above diagnosis and medical information, this person is not medically precluded form participation in equine assistive activities and/or therapies. I understand that S.H.A.R.E. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer the person to S.H.A.R.E. for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____

Signature: _____Date: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ License/UPIN Number: _____

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Authorization for Emergency Medical Treatment Form

Check all that apply: _ Volunteer _Rider/Participant _Staff

Please fill out EVERY space. You may state Not Applicable (NA) if necessary.

Name:_____ DOB:_____

Parent/Legal Guardian (if under 18):_____

Address: _____City:_____State:_____Zip:_____

Phone: (Home)_____(Work) _____(Cell)_____

Physicians Name:_____ Preferred Medical Facility: _____

Health Insurance Company: _____Policy #_____

Allergies to Medications:_____

Current Medications:_____

Health History

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations/surgeries or lifestyle changes:

_____

_____

In Case of Emergency contact:

Name:_____Relationship_____Phone:_____

Name:_____Relationship_____Phone:_____

Name:_____Relationship_____Phone:_____

Consent Plan

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize SHARE to

1) Secure and retain medical treatment ant transportation if needed.
2) Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, 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.

Date:_____ Consent Signature:_____
Client, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during process of receiving services or while being on the property of SHARE

☐ Parent or legal guardian will remain on the site at all times during equine assisted activities with the non-consent plan
☐ In the event of emergency treatment/aid is required; I wish the following procedure to take place:

_____
_____
_____
_____

Date:_____ Non-Consent Signature:_____
Client, Parent or Legal Guardian

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Liability Release Form

Name: _____ Age_____ Phone: _____

Address: _____City: _____

State: _____ Zip:_____ Email_____

UNDER SOUTH CAROLINA LAW: **AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN AN EQUINE ACTIVITY RESULTING FROM AN INHERENT RISK OF EQUINE ACTIVITY, PURSUANT TO ARTICLE 7, CHAPTER 9 OF TITLE 47, CODE OF LAWS OF SOUTH CAROLINA, I976.**

Assumption of Risk:

I acknowledge that the enjoyment and excitement of Horseback riding or otherwise handling horses is derived in part from the inherent risk incurred by this activity. I am solely responsible for my decision to participate in this activity. I understand and accept that Horseback riding or otherwise handling horses involves dangers and risks which may include, but are not limited to the following:

· Horse behavior or temperament which includes biting, kicking or stepping on a person;
· Falling off or being thrown from a horse, such risk increases at higher speeds;
· Unforeseen maladjustment or malfunction of saddles and tack;
· Horseback riding on rugged terrain, including slippery trails;
· Injuries inflicted by animals, insects, plants or other participants;
· Accidents or illness in remote places without medical facilities;
· The forces of nature including lightning, unsuspected changes in terrain, weather changes, and others
· The physical exertion associated with horseback riding or otherwise handling horses.
· This facility is not considered a spectator property. Anyone entering property is considered a participant.

Release Agreement

In consideration of SHARE Therapeutic Riding Program furnishing either horses and/or a place to enable me to participate in equine and farm related activities, I hereby assume all risk of injury or loss of life to myself, and loss of or damage to property arising out of my participation in such activities, including hazards associated with any defect in a manufacturer's product. I specifically release and hold harmless SHARE, its owners, operators, agents, volunteers, guides, employees, and participants from any and all liability, including negligence (active or passive), as to any right of action or claim to relief that may accrue either to me or to my heirs or personal representatives for any such injury, loss of life, medical costs, attorney's fees, court costs, or loss of or damage to property which I may suffer while participating in equine activities, including activities preliminary and subsequent thereto. I declare that I carry medical insurance fully covering any and all injuries incurred. I further understand SHARE carry no medical insurance for the protection of participants, and any insurance coverage existing with respect to SHARE, shall not alter the terms of this waiver nor impose any liability on SHARE. I have carefully read this release and fully understand its contents. I am aware that this is a complete release of liability and I sign it of my own free will. This release will remain in full force and effect for all visits by me to SHARE unless I explicitly revoke it in writing and deliver such revocation in person to SHARE. I hereby give permission to the medical personnel selected by SHARE personnel to order X-rays, routine tests and treatment for family, minor children and myself and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by SHARE personnel to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my family, minor children or myself as named above. I also agree to obey all Rules and all other posted signs or verbal directions while participating in any and all equine and/or farm related activities.

Signature of Participant: _____
(For participants under 18 years of age)
Signature of Parent or Guardian:_____

Print Name of Parent or Guardian:_____

SHARE Therapeutic Riding Program requires <u>ALL</u> riders to wear a helmet