PARTICIPANT QUESTIONNAIRE & HEALTH HISTORY

Has the participant had previous experience with therapeutic riding? Yes__ No__

Goals: What are you hoping to accomplish by participating at PARK HORSE PROJECT?

_____

_____

_____

_____

Comments: please give any info that you feel will be helpful in lesson planning.

_____

_____

_____

_____

Please answer the following to help us best prepare for your arrival and evaluation.

Does the participant...	**YES**	**NO**	**Comments**
Walk independently?			
Have poor balance sitting/standing balance?			
Have speech/language difficulties?			
Have problems with fine motor skills?			
Have problems with gross motor skills?			
Have allergies or breathing problems?			
Have pain?			
Have emotional/behavioral problems?			
Have heart/circulation problems?			
Have short term/long term memory loss?			
Have a fear of heights?			
Have a fear of horses or animals?			

SEIZURE INFORMATION FORM

Does the participant have seizures? Y N
If yes, please fill out the following form.

What may cause the seizures?

_____

_____

On average, how often do they occur?

_____

_____

Are there any warning signs before a seizure starts?

_____

_____

_____

What is the average duration of a seizure?

_____

How does the participant feel and behave after a seizure? How long does this last?

_____

_____

_____

How would you like us to handle the situation, should a seizure occur while riding?

_____

_____

_____

_____

Is there anything else that we need to know about the seizures?

_____

_____

PHYSICIAN'S REFERRAL FORM

To be Signed and Dated by Current Doctor

Patient' s Name: _____

Parent Name and Contact # _____

Patient's date of birth:_____ Height:_____ Weight: _____

Medical History

Diagnosis:_____ Date of onset: _____

Primary Disability: _____

Other Concerns: _____

Hospitalizations:_____

Shunts/Assistive Devices: _____

Seizures/Allergies:_____

Present Medications: _____

_____

Physical Evaluation

Skin/Circulation:_____ Neuro/Sensation:_____

Heart/Lungs:_____ Balance/Coordination:_____

Bowel:_____ Bladder:_____

Vision:_____ Hearing:_____

Speech:_____ Spasticity/Rigidity:_____

FOR PARTICIPANTS WITH DOWN SYNDROME:

Neurological exam for Atlantoaxial Instability: ___ Present ___Not present

Other Precautions/Contraindications to Therapeutic Horseback Riding:_____

_____

In my professional opinion, this patient is able to receive therapeutic horseback riding instruction under appropriate supervision at PARK HORSE PROJECT therapeutic horsemanship.

_____ _____

Physician's Signature Date

Physician's Name_____ Phone_____

Office Address _____

_____ _____

Parent/Guardian Signature.

THERAPIST REFERRAL FORM

If student is currently seeing a physical, occupational or speech therapist, please have them fill out this form and/or attach a recent evaluation.

Name of Participant _____Birthdate_____

_____

Diagnosis _____

Current Therapy_____

_____

Evaluations Used: _____

_____

Short Term Goals: _____

_____

Long Term Goals: _____

_____

Objectives: _____

Areas for Improvement: _____

Areas of Strength: _____

Precautions/Contraindications: _____

Cue Style (verbal/physical prompts): _____

Other: _____

_____ _____

Therapist Signature Date

_____ _____

Parent Signature Date

RELEASE OF LIABILITY AGREEMENT

Name of Participant:_____Name of Guardian:_____
Address:_____City & Zip_____
Telephone Number:_____
Emergency Contact: _____

PARK HORSE PROJECT Therapeutic Horsemanship Program is professionally organized and thoughtfully supervised. All staff, volunteers, and horses have been carefully selected. Safety equipment is used for all riders because horseback riding is a risky exercise.

No participant can be accepted into the PHP program until a parent or guardian has signed this form or if the rider is of legal age, he/she may sign. Therapeutic riding and Equine Assisted Learning instruction will be under strict supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted BY the organization, or any persons connected with the organization.

The undersigned as self or parent/guardian of said minor_____, hereby agrees to hold harmless and indemnify PARK HORSE PROJECT its officers, trustees, agents, employees, volunteers, representatives, and successors from all manner of liability, loss, costs, claims, demands and damages of any kind and nature whatsoever, which the undersigned may now or in the future have against the said facility.

I, _____(participant/volunteer), am aware of the risks of contracting/spreading communicable diseases/viruses while participating in face-to-face services from PARK HORSE PROJECT Therapeutic Horsemanship Program. I agree to cancel my session, should I exhibit or have been in contact with someone who has presented with illness symptoms.

PARK HORSE PROJECT will engage in regular cleaning/sanitization of horse tack, grooming supplies, office and gathering areas to reduce the risk of spread of communicable diseases.

I agree to follow these guidelines and hold harmless all individuals associated with or through my services acquired from PARK HORSE PROJECT Therapeutic Horsemanship Program.

Date: _____

Signed: _____

AUTHORIZATION FOR MEDICAL TREATMENT

Name of participant Name of Parent Or Legal Guardian

Participant's Date of Birth

Current Diagnosis

Current Medications

Allergies to Food/Medications

Date of last tetanus shot

Any special instructions

In the event, emergency medical treatment is required due to an illness or injury during a therapeutic riding session. I authorize PARK HORSE PROJECT to :

1. Call emergency medical help and consent to any necessary treatment that may include transportation, x-ray examination, surgery, medication, or hospitalization.
2. Release participant records upon request of authorized emergency medical personnel if needed. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Consent Signature: Date:

Emergency contacts

Telephone numbers where emergency contacts can be reached:

Print Name:_____

Phone Number:_____

Relation to participant: _____

Print Name:_____

Phone Number:_____

Relation to participant: _____

INFORMATION AND RESEARCH DATA RELEASE FORM

PARK HORSE PROJECT Therapeutic Horsemanship Program may receive requests from outside sources for release of information and/or data for participants, staff, and volunteers. The outside sources may include other centers, educators, judicial officers, other therapists/medical practitioners, or caseworkers. PARK HORSE PROJECT considers ALL participant information as confidential and will be treated as such. Release of personal information will only be conducted with written consent from the participants, staff, and volunteers of PARK HORSE PROJECT Therapeutic Horsemanship Program. Those whose information is requested from an outside source will have the opportunity to deny this request in writing.

Data obtained from evaluations both formal/informal while said person participates with PARK HORSE PROJECT in any capacity, can be used by PARK HORSE PROJECT for grant reporting and research in the field of equine assisted services.

Please check desired boxes below and sign/date:

	I agree to consent to release participant information to other parties as explained above
	I DO NOT agree to consent to release participant information to other parties as explained above
	I agree to consent to release of research data to other parties as explained above
	I DO NOT agree to consent to release or research data to other parties as explained above

Date:_____

Signed: _____

PHOTO/MEDIA RELEASE FORM

PARK HORSE PROJECT Therapeutic Horsemanship Program uses photographs or video of participants and/or their families for use in marketing materials, grants, press releases and social media. As a participant in any capacity with PARK HORSE PROJECT Therapeutic Riding Program, you have the right to consent/not consent to the use of photos/media in any form.

Please check desired box below & sign/date:

	I agree to consent to use of photos/video as explained above
	I DO NOT agree to consent to use of photos/video as explained above

Date: _____

Signed: _____