4STEPS Therapeutic Riding Program

5367A Sixty Foot Road Parsonsburg Maryland 21849
www.4stepstrp.org 410-835-8814 giddyup4steps@aol.com

Participants Application and Health History

To be completed by the participant, parent/legal guardian, or caregiver

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Please make sure to fill out both sides of this form

GENERAL INFORMATION

Participant_____

Date of Birth: _____ Age :_____ Height:_____ Weight: _____ M F

Address _____

_____

Phone: Home _____(Cell)_____Work: _____

email_____

Employer/School_____ Phone: _____

Parent/Guardian/Caregiver_____

Address (if different than above): _____

Referral Source: _____How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas (attach additional information).

	Yes/No	Comments
Vision		
Hearing		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional		
Behavioral		
Pain		
Bone/joint		
Muscular		
Thinking/cognitive		
Allergies		

What medications are you currently taking, including over the counter medications?

_____

Reviewed by_____Date_____ Reviewed by_____Date_____

Describe abilities/difficulties in the following areas. Include assistance required or equipment needed.

FUNCTION (mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____
_____

SOCIAL (work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears, concerns, etc…)

_____
_____
_____
_____
_____
_____

GOALS: (ie, why are you applying for participation? What would you like to accomplish?)

_____
_____
_____
_____
_____
_____

LIABILITY RELEASE

In consideration of 4STEPS TRP allowing my participation in this activity I agree to hold harmless and release 4STEPS TRP from legal liability except in the event of 4STEPS TRP gross and willful negligence, I shall bring no claims, demands, actions and causes of action, and/or litigation, against 4STEPS TRP for any economic and non-economic losses due to bodily injury, death, property damage, sustained by me in relation to the premises and operations of 4STEPS TRP to include while learning about riding, or while riding, handling, or otherwise being near horses owned by or in the care, custody and/or control of 4STEPS TRP. Having received the participant's manual, I UNDERSTAND THE ASSUMPTION OF RISK.

Name (Print) _____Relationship to rider_____

Signature _____Date _____

PHOTO RELEASE

I DO ☐
I DO NOT ☐

consent to and authorize the use and reproduction by 4STEPS TRP of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Name(Print)_____Relationshiptorider_____

Signature_____ Date_____

4STEPS Therapeutic Riding Program

4STEPS is a Member Center of Professional Association of Therapeutic Riding Intl. (PATHIntl.)

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MUST BE FILLED OUT AND SIGNED BY YOUR PHYSICIAN

Participant's Medical History & Physician's Statement (*use back to report additional information*)

Participant: _____ 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 Devices _____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date: _____ Result: + --
Neurologic Symptoms of AtlantoAxial Instability: _____

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

	YES/NO	COMMENTS
Auditory		
Tactile		
Speech		
Vision		
Cardiac/Circulatory		
Skin		
Pulmonary		
Immune		
Neurologic		
Muscular		
Balance		
Orthopedic		
Allergies		
Learning disability		
Emotional/psychological		
Pain		
Other		

Given the above diagnosis and medical information, this person is not medically precluded from participating in supervised equine assisted activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation in determining eligibility for participation.

Name/Title _____ MD DO NP PA Other _____

Signature _____ Date _____
Address _____
Phone _____ License/UPIN Number _____

Reviewed by_____ Date_____