Kentucky Foothills
Therapeutic Equestrian Center
7822 Hwy 2004
McKee, KY 40447
606-965-2158~mykfthc@gmail.com~www.kfthc.org

No participant may be accepted for therapeutic horsemanship services until all forms have been completed.
Forms are required to be annually updated
If the participant is of legal age and mentally competent, he/she may complete the forms without a parent's or guardian's signature.

Participant Name: _____Age: _____ DOB: _____

Sex: M F Height: _____ Weight: _____ Diagnosis/Concern: _____

Parent/Legal Guardian (if any): _____

Address: _____ City:_____ State/Zip: _____

Phone: _____ Second Phone (if any): _____

Email: _____

Emergency Contact: _____ Relationship: _____Phone: _____

How did you hear about this program?

PHOTO RELEASE

I ☐ DO or ☐ DO NOT consent to and authorize the use of and reproduction 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 by and for the benefit of the Kentucky Foothills Therapeutic Horsemanship Center.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF FEE PAYMENT RESPONSIBILITY

As the financially responsible party I acknowledge and accept the responsibility of timely payment for Equine Assisted Activities and Therapies at KFTHC.

$40.00 per lesson is the standard fee payable on the day of the ride. Cash, Check, Paypal and/or Venmo are all acceptable. Participants with Negative Balances may be dismissed from the schedule.

Participants with repeated cancellations may be dismissed from the schedule.

Participants missing after confirming are expected to make payment for the scheduled service.

Signature: _____ Date: _____

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Date: _____

Dear Health Care Provider,

Your patient _____

(Participant's Name)

is interested in participating in supervised equine assisted 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:	**Medical/Psychological:**
Atlantoaxial Instability- include neurological symptoms Coxa Arthrosis Cranial Deficits Heterotropic Ossification/Myositis Ossificans Joint Subluxation/Dislocation Pathologic Fractures Spinal Joint Fusion/Fixation Spinal Joint Instability/Abnormalities **Neurologic** Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II Malformation/ Tethered Cord/ Hydromyelia **Other:** Indwelling Catheter/ Medical Equipment Medications- ie photosensitivity Poor Endurance Skin Breakdown	Allergies Animal Abuse Cardiac Condition Physical/Sexual/Emotional Abuse Blood Pressure Control Dangerous to Self or Others Exacerbations of Medical Conditions (ie RA, MS) Fire Setting Hemophelia Medical Instability Migraines PVD Respiratory Conditions Recent Surgeries Thought Control Disorders Weight Control Disorder

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in Equine Assisted Activities, please feel free to contact us at the center or at the phone/address listed above.

Sincerely,

Cheryl Martin, M.Ed. PATH, Intl. Registered Instructor, KFTHC Program Director

PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____

Diagnosis: _____ Weight: _____

Past/Prospective Surgeries: _____

Medications : _____

Seizure: Y N 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: _____

	Yes	No	Comments: Please indicate current or past special needs in the following systems/areas.
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised Equine Assisted Activities. However I understand that the PATH, intl. Center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. OT, PT, SLP, Psychologist, etc) in the implementation of an effective equine assisted activity program.

Name/Title: _____ MD, DO, NP, PA, Other: _____

Signature: _____ Date: _____

Address _____

Phone: _____ License/UPIN # _____

Kentucky Foothills Therapeutic Horsemanship Center

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
PARTICIPANT

Name: _____ DOB: _____ Phone:_____

Address: _____

Physician's Name: _____ Preferred Medical Facility; _____

Health Insurance Co.: _____Policy #: _____

Allergies to Medications: Y N Current Medications: _____

Persons to be contacted in case of an emergency:
1. NAME: _____ RELATIONSHIP:_____ PHONE: _____

2. NAME: _____ RELATIONSHIP:_____ PHONE: _____

3. NAME: _____ RELATIONSHIP:_____ PHONE: _____

In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while on the property of the agency, I authorize the Kentucky Foothills Therapeutic Horsemanship Center, Inc. to:
1. Secure and retain medical treatment and transportation, if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the emergency treatment.

Consent Plan:
This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed "life saving" by the physician. This provision will only be invoked if the persons listed above are unable to be reached.

Consent Signature: _____ Date: _____
Signature of parent or guardian if participant is under 18

Non Consent Plan: (Parent or Legal Guardian must remain on site at all times during Equine Assisted Activities.)

_____ **I do not** give my consent for emergency medical treatment/aid in the case of illness or injury while on the property of the agency
Non Consent Signature: _____ Date: _____
Signature of parent or guardian if participant is under 18

Kentucky Foothills Therapeutic Horsemanship Center

CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

Although every effort will be made to avoid accident of injury, NO LIABILITY can be accepted by any of the organizations concerned including KFTHC, its officers, trustees, agents, employees, each and every one of its members, volunteers or associates or the property owners upon whose land the therapy sessions are conducted.

I request and consent to treatment that may include therapy and I have discussed this type of therapy with my/my child's doctor.

LIABILITY RELEASE

_____ (Participant's Name) would like to participate in KFTHC's program. I acknowledge the risks and potential of risk for activities involving equines. I feel, however, that the possible benefits of Equine Assisted Activities to myself/my child, or my ward are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs or assigns, executors or administrators, waive and release all claims for damages against KFTHC, Inc., its Board of Trustees, Employees, Instructors, Therapists, Aids, Volunteers, Equines, Equine Owners, Equipment or Operating Site or the Owners of Jacks Creek Riding Stables, or Forgotten Roads Farm for any and all injuries and/or losses I/my child/my ward may sustain while participating at KFTHC, Inc.

"WARNING UNDER Kentucky law a farm animal activity sponsor, a farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities."
I understand that no liability can be accepted by any of the organizations concerned with this therapy.

Dated signatures of parent/guardian or participant of legal age must be included.

Participant's Name: _____

Signed: _____ Date: _____

Kentucky Foothills Therapeutic Horsemanship Center

PARTICIPANT WAIVER FORM

Participating at Kentucky Foothills Therapeutic Horsemanship Center (KFTHC) is a rewarding job but it is not without risks. While we strive to make KFTHC a safe environment for all of our guests, we ask that you observe our rules of safety at all times.

By signing, you agree that you are participating on your own behalf and release KFTHC, its director, officers, board members and staff from all claims, injuries, or actions (including those of active or passive negligence) arising from any activities in which you participate at KFTHC.

By signing, you understand the risks and hazards inherent upon entering the facility during a health crisis and assume all risks of loss, contraction of illness, damage, or injury, including death, that may be sustained while at KFTHC or while performing activities for KFTHC at one of its events or functions.

By signing, you represent that you are 18 years of age and of sound mind. If you are under 18, a parent or guardian must sign this form as well.

_____ _____

Signature Printed Name

_____

Date

Kentucky Foothills Therapeutic Horsemanship Center

PARTICIPANT'S HEALTH HISTORY

Participant's Name: _____ DOB: _____

Diagnosis: _____ Date of Onset: _____

Medications: _____

Medical Equipment: _____

Adaptive Equipment: _____

Other: _____

Please indicate current or past special needs in the following areas;

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Allergies			

PARTICIPANT'S HEALTH HISTORY continued

Describe abilities/difficulties in the following areas (include assistance required)

PHYSICAL FUNCTION: i.e., Mobility skills such as transfers, walking, wheelchair use, driving, etc.)

PSYCHO/SOCIAL FUNCTION (i.e., Work/school, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

GOALS: (i.e. What do you hope to gain from participation? What would you like to accomplish?)

OTHER INFORMATION WE MIGHT FIND HELPFUL?

This form was completed by: _____Date: _____

Relationship to participant: _____

KFTHC
Questionnaire for Parents

Name:_____ Son/Daughter Name: _____

Date: _____ Birth Date: _____

Son/daughter's diagnosis (if any):

1. These are some things I like about my son/daughter.

2. These are some things my son/daughter does well.

3. These are some things my son/daughter enjoys.

4. These are some things my son/daughter does not like.

5. These are some things I'd like my son/daughter to learn.

6. My son/daughter HAS/ HAS NOT had any horse experiences. (Circle one) If your son/daughter HAS had experiences with horses, please describe.

7. The reason we came to KFTHC to be involved with horses is:

KFTHC
Questionnaire for Participants

Name:_____ Date: _____

Birth Date: _____

Diagnosis (if any):

1. These are some things I like about myself.

2. These are some things I do well.

3. These are some things I enjoy.

4. These are some things I do not like.

5. These are some things I'd like to learn.

6. I HAVE/ HAVE NOT had any horse experiences. (Circle one) If you HAVE had experiences with horses, please describe.

7. The reason I came to KFTHC is: