BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

SpiritHorse International®

Participant Application / Registration – 2025

Name of Rider_____Birthdate_____Height____Weight_____

Address_____Home Phone_____

City, State, Zip_____Cell Phone_____

E-mail_____

Is Rider a member or veteran of the Armed Forces, Police or Fire Service?_☐_Yes _☐_No

If under 18 years of age, or over 18 and under guardianship, COMPLETE THE FOLLOWING: Name of School_____

Fathers/Guardian Name: _____Mothers/Guardian Name _____

Address_____Address_____

City/State/Zip_____City/State/Zip_____

Phone_____Phone_____

Email_____Email_____

Employer_____Employer_____

EMERGENCY CONTACT (other than parent or guardian)

Name_____Phone_____

Relationship_____Cell_____

Is Rider currently enrolled in:

Physical Therapy ☐ Yes ☐ No

Occupational Therapy ☐ Yes ☐ No

Speech Therapy ☐ Yes ☐ No

Behavioral/Psychological Therapy ☐ Yes ☐ No

Explain therapy involvement_____

_____

_____

_____

_____

_____

_____

HOW DID YOU HEAR ABOUT BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.?

☐ Newspaper ☐ Radio/TV ☐ Poster ☐ Volunteer ☐ Another Organization ☐ Other_____

HAS RIDER EVER RIDDEN A HORSE BEFORE? ☐ YES ☐ NO

IS RIDER WILLING TO ATTEND EVERY CLASS? ☐ YES ☐ NO

IS THERE A PARENT, GUARDIAN, SIBLING, OR OTHER PERSON INTERESTED IN HELPING DURING THE RIDER'S CLASS TIME? IF SO, NAME_____

ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD BE HELPFUL TO BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC._____

Mailing Address: Baraboo River Equine-Assisted Therapies, Inc. (BREATHE),
P.O. Box 101, Baraboo, WI 53913

BARABOO RIVER EQUINE-ASSISTED THERAPIES, INC.

This form must be completed and signed by the participant's physician or referring licensed medical professional.

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RIDERS MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Rider Name:_____DOB: _____
Required to match to a horse: **Height: _____Weight: _____Body shape: Apple___Pear___Stringbean___**
Address: _____
Primary Diagnosis: _____Date of Onset: _____
Secondary Diagnosis: _____Date of Onset: _____
Shunt Present: ☐ Yes Date of last revision: _____
Mobility: Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair ☐
Braces/Assistive Devices: _____
For those with Down Syndrome: AtlantoDens Interval X-rays, Date_____Result: + -
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past special needs in the following system/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Additional Physician Instructions noted on reverse side of this form: ☐ YES ☐ NO

Physician's Statement
Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the Baraboo River Equine-Assisted Therapies, Inc., will weigh the medical information given against the existing precautions and determine eligibility for participation.
Name/Title_____MD DO NP PA Other_____
Signature:_____Date_____
Address:_____
Phone:_____License/UPIN Number_____

MEDICATIONS: (include prescription, over the counter, name, dose, and frequency) _____

_____

_____

_____

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

PHYSICAL FUNCTION: (i.e., mobility skills such as core strength, walking with or without assistance, wheelchair use, vision, hearing, specific tactical or sensorty sensitivities, etc)

_____

_____

_____

PSYCHO/SOCIAL FUNCTION: (i.e., work/school including grade completed, leisure interests, relationship-family structure, support systems, companion animals, fears, concerns, etc.)

_____

_____

_____

GOALS: (i.e., Why are you applying for participation? What would you like to accomplish?) _____

_____

_____

_____

_____

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- ☐ Spinal Fusion
- ☐ Spinal Instabilities/Abnormalities
- ☐ Atlantoaxial Instabilities
- ☐ Scoliosis
- ☐ Kyphosis
- ☐ Lordosis
- ☐ Hip Subluxation and Dislocation
- ☐ Osteoporosis
- ☐ Pathologic Fractures
- ☐ Coxas Arthrosis
- ☐ Heterotopic Ossification
- ☐ Osteogenesis Imperfecta
- ☐ Cranial Deficits
- ☐ Spinal Orthoses
- ☐ Internal Spinal Stabilization Devices

Neurologic

- ☐ Hydrocephalus/shunt
- ☐ Spina Bifida
- ☐ Tethered Cord
- ☐ Chiari II Malformation
- ☐ Hydromyelia
- ☐ Paralysis due to Spinal Cord Injury
- ☐ Seizure Disorders

Medical/Surgical

- ☐ Allergies
- ☐ Cancer
- ☐ Poor Endurance
- ☐ Recent Surgery
- ☐ Diabetes
- ☐ Peripheral Vascular Disease
- ☐ Varicose Veins
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Serious Heart Condition
- ☐ Stroke (Cerebro-vascular Accident)

Secondary Concerns

- ☐ Behavior problems
- ☐ Age less than two years
- ☐ Age two-four years
- ☐ Acute exacerbation of chronic
- ☐ disorder Indwelling catheter

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LIABILITY, PHOTO, MEDICAL CONSENT RELEASE
NEEDS TO BE COMPLETED FOR ALL RIDERS, VOLUNTEERS and STAFF
PARENT/GUARDIAND SIGNATURE FOR ANY PARTICIPANT UNDER AGE OF 18

LIBILITY RELEASE

I/ my child/ my ward would like to participate in the Baraboo River Equine-Assisted Therapies, Inc. (BREATHE) Program as a rider, volunteer, or staff person. I acknowledge the risk and hazardous nature of horse activities and horseback riding. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs, assigns, executors or administrators, waive and release forever all claims for damages against Baraboo River Equine-Assisted Therapies, Inc., its Board of Directors, instructors, therapists, aides, volunteers, horse owners and/or employees for any and all injuries and/or losses that I/ my child/ my ward may sustain while traveling to or from, or participating in any BREATHE activities.

Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Wisconsin State Statutes Sec. 95.481

Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack in the instruction of a person in the riding or driving of equine or in being a passenger upon an equine is not liable for injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in Section 895.481 (1) (e) of the Wisconsin State Statutes.

PHOTO RELEASE

I_DO_DO NOT consent to and authorize the use and reproduction by Baraboo River Equine-Assisted Therapies, Inc., of all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or another use for the benefit of the program.

Signature:_____ Date: _____

Parent or Guardian:_____ Date: _____

MEDICAL TREATMENT CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or any other use for benefit of the agency.

I DO AUTHORIZE Baraboo River Equine-Assisted Therapies, Inc. to:

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

This authorization includes x-ray, 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.

Consent Signature_____ Date_____

MEDICAL TREATMENT NON-CONSENT PLAN

I DO NOT give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency.

☐ Parent or legal guardian will always remain on site during equine assisted activities.

☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

_____

Non-Consent Signature_____ Date_____

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