



PARTICIPANT EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Name: _____ Date: _____

Address: _____ DOB: _____

City/State/Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ 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 SETC 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 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 case of illness or injury while being on SETC property.

- Parent or legal guardian will remain on site at all times during equine assisted activities.
- In the event emergency treatment/aid is required, I wish the following procedure to take place:

Date: _____ Non-Consent Signature: _____

Client, Parent or Legal Guardian



PARTICIPANT'S APPLICATION & HEALTH HISTORY

GENERAL INFORMATION

Participant: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Gender: M F

Address: _____ DOB: _____

City/State/Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Address: _____

Phone: _____ E-mail: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone: _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Bone/Joint			

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 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?)

Signature: _____ Date: _____

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION



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

The information is to be released to Special Equestrians of the Treasure Coast 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
- Speech therapy evaluation, assessment and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial 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: _____

Relation to Participant: _____

Please send materials to: _____

Date: _____

Dear Health Care Provider:



Your patient, _____ is interested in participating in supervised equine activities.
(*participant's name*)

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

- Atlantoaxial Instability - include neurologic symptoms
- Coxarthrosis
- Cranial Defects
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

Neurologic

- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

- Age - under 4 years
- Indwelling Catheters/Medical Equipment
- Medications - i.e. Photosensitivity
- Poor Endurance
- Skin Breakdown

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical/Sexual/Emotional Abuse
- Blood Pressure Control
- Dangerous to Self or Others
- Exacerbations of Medical Conditions (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- 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 assisted activities, please feel free to contact Special Equestrians at Post Office Box 651312, Vero Beach, Florida 32965. Telephone: (772) 562-7603.



PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

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 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			
Emotional/Mental Health			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____



PARTICIPANT'S PROFILE

Name: _____ Date: _____

Disability: _____

Ambulatory Status: _____

Adapted Equipment Required: _____

Mounting/Dismounting (method, number of volunteers) _____

Helpers required (indicate gait* assistance needed; update as needed):

Type of Assistance	Date	Gaits	Date	Gaits	Date	Gaits	Date	Gaits
Leader and 2 sidewalkers								
Leader and 1 sidewalker								
Leader only								
Sidewalker								
Independent								

Riding Position (describe): _____

Riding Skills (indicate gait*/task is completed; update as needed):

Task	Date	Gaits	Date	Gaits	Date	Gaits	Date	Gaits
Holds reins								
Holds handhold								
Able to control horse								
Able to halt from the ...								
Able to circle at the ...								
Rides without stirrups								
Able to maintain half seat								
Able to post at the ...								
Knows diagonal or lead								
Able to steer over cavalletti								
Able to jump a crossbar								

Rider can walk _____ sitting trot _____ posting trot _____ canter _____

Horse recommendations _____

(write any additional comments on the reverse side)

*Gait Key: W - walk; ST - sitting trot; PT - posting trot; C - canter

PARTICIPANT RELEASE AGREEMENT



LIABILITY

The undersigned, for good and valuable consideration received from or on behalf of the Special Equestrians of the Treasure Coast, Inc. the receipt and sufficiency of which is hereby acknowledged, does hereby remise, release, acquit, satisfy and forever discharge and hold harmless the Special Equestrians of the Treasure Coast, Inc. its officers, directors, trustees, agents, employees, representatives, successors and assigns (collectively "SETC"), of and from any and all manner of action and actions, causes and causes of action, suits, debts, dues, sums of money, accounts, reckonings, bonds, bills, specialties, covenants, contracts, controversies, agreements, promises, variances, trespasses, damages, judgments, executions, claims, benefits, rights and demands whatsoever, in law or in equity, of whatever nature or kind, known or unknown, which the undersigned may now, or in the future, have against SETC on account of any personal injury, physical or mental condition or any other damage, known or unknown, to the undersigned and the treatment thereof, as a result of, or in any way growing out of the acts of SETC, including, but not limited to their negligence or gross negligence or as a result of any other action or activity engaged in by the undersigned in any way involving relationship with the Special Equestrians of the Treasure Coast.

NEWS AND PHOTOS

The undersigned hereby grants to SETC, permission to take or have taken still and moving photographs and films, including television pictures of myself/son/daughter/spouse. I consent and authorize SETC to use and reproduce the photographs, films, pictures, and to circulate and publicize the same by all means, including without limiting media, brochures, pamphlets, instructional material, books, clinical material, newspapers, magazines, and the internet.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure my signature(s) to this release other than the intention of SETC to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding SETC and its work.

CONFIDENTIALITY

Any information in regards to the participants at SETC must be held in strict confidentiality. Confidentiality is defined as "told in secret or private relations; trusted." Your signature below confirms that you will abide by this policy.

WARNING

Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

Dated this _____ day of _____, _____.

Printed Name

Signature

Parent/Guardian (if applicable)