Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

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

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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			
Thinking/Cognition			
Allergies			

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: _____

PHOTO RELEASE

I DO

DO NOT

consent to and authorize the use and reproduction by HeadWinds LLC / HeadWinds Therapeutic Horsemanship 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.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Participant's Medical History & Physician's Statement

Dear Health Care Provider:

Your patient, _____

(participant's name)

is interested in participating in therapeutic horseback riding and/or supervised equine 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

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 the center at 209.536.9268 HeadWinds 13639 Kincaid Flat Rd. Sonora Calif. 95370

Sincerely,

Kiki Edgerton TRI, ESMHL, CRI
HeadWinds Therapeutic Horsemanship .
kiki_edgerton@yahoo.com http://headwindsllc.org 209.536.9268

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:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
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 HeadWinds LLC, a PATH Int center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to HeadWinds LLC, a PATH Int. center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) _____ License/UPIN Number: _____

About PATH Int.

Professional Association of Therapeutic Horsemanship International (PATH Intl.), a federally-registered 501(c3) nonprofit, was formed in 1969 as the North American Riding for the Handicapped Association to promote equine-assisted activities and therapies (EAAT) for individuals with special needs. With more than 4,200 certified instructors and equine specialists and nearly 850 member centers around the globe, more than 7,400 PATH Intl. members help 56,000 children and adults with physical, mental and emotional challenges find strength and independence through the power of the horse each year. In addition to therapeutic riding, our centers offer a number of therapeutic equine-related activities, including hippotherapy, equine-facilitated mental health, driving, interactive vaulting, competition, ground work and stable management. More recently, programs offer services in human growth and development to serve wide-ranging audiences for such educational purposes as leadership training, team building and other human capacity enhancement skills for the workplace and for daily use.

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____

Address: _____

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 ___HeadWinds LLC / HeadWinds Therapeutic Horsemanship___ 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 medical emergency 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
Signed in presence of center staff

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 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
Signed in presence of center staff

Participant's Consent for Release of Information

I hereby authorize: _____

(person or facility)

to release information from the records of: _____ DOB: _____

(participant's name)

The information is to be released to: *HeadWinds LLC 13639 Kincaid Flat Rd. Sonora, Calif. 95370*
Kiki Edgerton , TRI, ESMHL, CRI 209.536.9268

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- o Medical history
- o Physical therapy evaluation, assessment and program plan
- o Speech therapy evaluation, assessment and program plan
- o Mental health diagnosis and treatment plan
- o Individual Habilitation Plan (I.H.P.)
- o Classroom Individual Education Plan (I.E.P.)
- o Psychosocial evaluation, assessment and program plan
- o Cognitive-behavioral management plan
- o 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: _____

Please send materials to: _____

Please send materials to: _____

Please send materials to: _____

Rider Profile

Name:_____

Daytime Phone_____ Evening

Phone_____

Address_____

City, State, ZIP_____

E-Mail Address_____

Experience: Beginner__ Basic ___ Intermediate___ Advanced___ Trainer ___ Other ___

Riding experience

_____

_____

_____

Primary Interest / disciplines

_____

_____

_____

_____

Goals for both you and your horse

_____

_____

_____

_____

_____

Please provide any other pertinent experience and information:

_____

_____

_____

_____

I understand that the information provided will be used to make instructional decisions and or horse assignments. I hereby attest that all the information provided is true and no relevant information has been omitted.

Signature of rider _____ Date _____

Signatures of a parent or guardian are required for participants under 18 years of age.
Parent or guardian _____ Date _____
Parent or guardian _____ Date _____

Equine Activity Liability Release and Hold Harmless Agreement

1. I, _____, the undersigned have read and understand, and freely and voluntarily enter into this Release and Hold Harmless Agreement with Kiki (KristiAnn) Edgerton, Jeremiah Seth Houck and HeadWinds LLC / HeadWinds Therapeutic Horsemanship At 13639 Kincaid Flat Rd. Sonora, Calif. 95370
understanding that this Release and Hold Harmless Agreement is a waiver of any and all liability(ies).

_____ 2. I understand the potential dangers that I could incur in handling said horses, including grooming, leading, mounting, riding, walking, and feeding said horse; including, but not limited to, any interactions with other horses. Understanding those risks I hereby release Kiki (KristiAnn) Edgerton, Jeremiah Seth Houck and HeadWinds LLC / HeadWinds Therapeutic Horsemanship, property owners, officers, directors, shareholders, employees and anyone else directly or indirectly connected with Kiki (KristiAnn) Edgerton, Jeremiah Seth Houck and HeadWinds LLC / HeadWinds Therapeutic Horsemanship from any liability whatsoever in the event of injury or damage of any nature (or perhaps even death) to me or anyone else caused by or incidental to my electing to participate in any activities and/or mount and ride a horse owned or operated by Kiki (KristiAnn) Edgerton, Jeremiah Seth Houck and HeadWinds LLC / HeadWinds Therapeutic Horsemanship, property owners, officers, directors, shareholders, employees and anyone else directly or indirectly connected with Kiki (KristiAnn) Edgerton, Jeremiah Seth Houck and HeadWinds LLC / HeadWinds Therapeutic Horsemanship.

_____ 3. I understand and recognize and warrant that this Release and Hold Harmless Agreement, is being voluntarily and intentionally signed and agreed to, and that in signing this Release and Hold Harmless Agreement I know and understand that this Release and Hold Harmless Agreement may further limit the liability of equine professionals to include any activity, whatsoever, involving an equine, including death, personal injury and/or damage to property.

_____ 4. I recognize and agree that I know which equine professional(s) I will be working with, and acknowledge that I agree said equine professional(s) has/have made reasonable and prudent efforts to determine my ability to engage in the equine activity, and has/have sufficient knowledge of my equine and horseback riding skills as to relieve, release and hold harmless said equine professional(s) from any continuing duty to monitor my equine activities.

_____ 5. I further voluntarily agree and warrant to Release and Hold Harmless this (these) equine professional(s) from any liability whatsoever, including, but not limited to, any incident caused by or related to said equine professional's (s') negligence, relating to injuries known, unknown, or otherwise not herein disclosed; including, but not limited to, injuries, death or property damage from: mounting; riding; dismounting; walking; grooming; feeding; use of horse barn, paddock, trails or horse ring, in any capacity; falling off horse whether horse is bucking, flipping, spooked; or my failure to understand any equine professional's directions relating to my riding or otherwise use and control, or lack thereof, of my horse or the horse I have been assigned to.

Date: _____
Stable/ Company/ Property Owner: HeadWinds LLC / HeadWinds Therapeutic Horsemanship

_____

Person voluntarily entering into this Release and Hold Harmless Agreement:

Signature _____

Printed Name _____

If minor, person representing himself/herself to the lawful Guardian under this Release and Hold Harmless Agreement:

Signature _____

Printed Name _____