Healing Horse Therapy Center

1752 C Road, Loxahatchee Groves, FL 33470
561-914-1718 info@healinghorse.org

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International
— MEMBER —

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:

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

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MEDICATIONS (include prescription and over-the-counter; name, dose and frequency)____________________

____

____

____

____

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

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

____

____

____

____

PSYCHO/SOCIAL FUNCTION (e.g.,. 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 Healing Horse Therapy Center 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

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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 Healing Horse Therapy Center 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

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

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Release of Liability

I, ____________________________ the undersigned, adult, client, or parent or guardian of________________________ , a minor, would like to participate at Healing Horse Therapy Center.

I acknowledge the risks and potential for risks of horseback riding. I understand that I/my/son/daughter/ward, will be working and around horses, as well, as riding horses of Healing Horse Therapy Center, Inc. However, I feel that the possible benefits to myself/son//daughter/ward are greater than the risk assumed. I, the undersigned client and/or parent or guardian, hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrator, waive and forever release, acquit, discharge and hold harmless all claims for damages against Healing Horse Therapy Center, its board of directors, trustees, agents, instructors, therapists, employees, representatives, volunteers, owners of property on which Healing Horse Therapy Center operates, successors or assigns.

WARNING

Under Florida Equine Activities statutes (Chapter 773), 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.

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING LIABILITY RELEASE.

Signature: ____ Date: ___________________
Client, Parent or Legal Guardian

Healing Horse Therapy Center

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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 neurological 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 – e.g., 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 Medial Conditions (e.g., 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 the address/phone indicated above.

Sincerely,

Maurette Hanson

Executive Director

Healing Horse Therapy Center

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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			
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 PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Name/Title:____ MD DO NP PA Other_________
Signature:____ Date: __________________
Address:____
Phone: ____ License/UPIN Number:________________