**Participant’s Application & Health History**

**GENERAL INFORMATION**

Participant:

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

Address:

Phone: Email: 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 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 Prancing Horse.

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

Date:

Dear Health Care Provider:

Your patient

 *(Participant’s name)*

is interested in participating in 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 Medical/Psychological**

Atlantoaxial Instability - include neurologic symptoms Allergies

Coxarthrosis Animal Abuse

Cranial Defects Cardiac Condition

Heterotopic Ossification/Myositis Ossificans Physical/Sexual/Emotional Abuse

Joint subluxation/dislocation Blood Pressure Control

Osteoporosis Dangerous to Self or Others

Pathologic Fractures Exacerbations of Medical Conditions (e.g., RA, MS)

Spinal Joint Fusion/Fixation Fire Settings

Spinal Joint Instability/Abnormalities Hemophilia

 Medical Instability

**Neurologic** Migraines

Hydrocephalus/Shunt PVD

Seizure Respiratory Compromise

Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia Recent Surgeries

 Substance Abuse

**Other** Thought Control Disorders

Age - under 4 years Weight Control Disorder

Indwelling Catheters/Medical Equipment

Medications - e.g., Photosensitivity

Poor Endurance

Skin Breakdown

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.

**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:* Neurologic Symptoms of Atlantoaxial Instability: Present Absent**

***Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.***

|  |  |  |  |
| --- | --- | --- | --- |
|  | Y | N | Comments |
| Auditory |  |  |  |
| Visual |  |  |  |
| Tactile Sensation |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Integumentary/Skin |  |  |  |
| Immunity |  |  |  |
| Pulmonary |  |  |  |
| Neurologic |  |  |  |
| Muscular |  |  |  |
| 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:

**Prancing Horse Center for Therapeutic Horsemanship**

**Release Of Liability, Waiver Of Right To Sue: Release Of All Claims: Indemnity Agreement**

**Warning: Under NC Law an equine activity sponsor or equine professional is not liable for the injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities chapter 99E NC General Statutes.**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_reside at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_State, Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On behalf of myself, my personal representatives, heirs, next of kin, spouse, and assigns hereby acknowledge that horseback riding involves serious risks and that it is not possible to foresee or prevent all such risks. I am aware that the fall of a rider from a horse and other accidents involving the horse rider and the volunteers assisting can be caused by sudden, unforeseen occurrences and that a fall or other accident can be crippling or fatal to the rider or volunteer and may cause an injury to or the death. I understand that the behavior of horses can be unpredictable and irrational regardless of their past training and past performance.**

**In light of the above, I voluntarily assume the risk and danger of injury or death inherent in the use of the horse, equipment and gear provided to me by PRANCING HORSE, INC., and/or its employees, owners and agents and volunteers.**

**I agree to and do Release, Discharge, and Promise Not to bring a lawsuit against Prancing Horse, Inc. doing business under their own name or any other names and/or any of their owners, officers, employees, agents, or volunteers.**

**I agree and promise to hold Prancing Horse, Inc., their employees and agents and volunteers, harmless and to fully indemnify then from and against any claim, judgment, or expense that may incur arising out of or in any way connected with either my use of the horse and any equipment provided therewith or the facility and landowners, or any acts or omissions of other employees and agents and volunteers.**

**I agree to abide by and follow any instructions given or rules established by Prancing Horse, Inc. or any of their employees, owner, agents and volunteers.**

**The laws of the State of North Carolina shall govern this release and waiver. If a court holds any portion of this release invalid, it is agreed that the remainder of this release shall continue in full legal force and effect notwithstanding the invalidity of some part of it.**

**I HAVE READ THIS DOCUMENT. I UNDERSTAND IT IS A PROMISE NOT TO SUE AND A RELEASE AND INDEMINITY FOR ALL CLAIMS. I SIGN THIS RELEASE VOLUNTARILY.**

**Sigature Parent, Legal Guardian for Minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_**

**Rider Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Volunteer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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: Prancing Horse, Inc

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: Prancing Horse, Inc

 PO Box 327,

 Southern Pines, NC 28388