**Participant Application and Health History**

**(To be completed by the participant or parent/legal guardian)**

**GENERAL INFORMATION**

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source:

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, frequency)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**PHOTO RELEASE**

I  DO

I  DO NOT

Consent to and authorize the use and reproduction by Reins of Rhythm any and all photographs and any other audio/visual materials taken of me for promotional materials,

educational activities, exhibitions or for an other use for the benefit of this program, and I give all rights of the photograph(s) to Reins of Rhythm for its use.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client, Parent, or Legal Guardian*

Date: \_\_\_\_\_\_\_\_\_\_

**Authorization for Emergency Medical Treatment**

**Rider**  **Volunteer**  **Employee** 

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of an emergency, contact:

|  |  |  |
| --- | --- | --- |
| **Name:** | **Relation** | **Phone:** |
|  |  |  |
|  |  |  |
|  |  |  |

I understand that I am responsible for my own care and medical condition and that I will let my emergency contact(s) know the times when I will be present at Reins of Rhythm’s program facility. In the event emergency medical aid/treatment is required due to illness or injury during the course of giving or receiving lessons or while being on the property of the program, and if the program cannot

reach my emergency contact(s), I authorize Reins of Rhythm to:

1. Contact and retain medical treatment and transportation, if needed.

2. Release my records upon request to the authorized individual or agency involved in the medical

emergency treatment.

**Consent Plan**

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 contact(s) above cannot be reached.

Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rider, Volunteer, Parent/Guardian of Rider or Volunteer*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 at the Reins of Rhythm facility. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Non- Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rider, Volunteer, Parent/Guardian of Rider or Volunteer*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT RELEASE AND HOLD HARMLESS AGREEMENT**

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Inherent Risks of Equine Activities**

Anyone who participate in any kind of activities on or about horses, including riding, training, assisting in medical treatment of horses, driving or being a passenger on a horse, or assisting a participant in a horse show or assisting show management, but does not include merely being a spectator to an equine activity, is considered to be engaged in an equine activity.

Equine activities hold inherent risks, defined by statute to include:

(1) the propensity of horses to behave in ways that may result in injury, harm, or death to persons on or around them;

(2) the unpredictability of a horse’s reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals;

(3) certain hazards such as surface and subsurface conditions;

(4) collisions with other horses or objects;

(5) the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

* **Acknowledgement of Risk**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have read the above statements and definitions, and hereby indemnify and hold harmless, REINS OF RHYTHM RIDING & HORSEMANSHIP

and their employees or owners from any liability arising from accident, injury, theft, or damages to myself, my representatives, and helpers, all equipment and property, and all animals under my jurisdiction. I understand that I must wear a helmet, secured with a harness, at all times when mounted at Reins of Rhythm Riding & Horsemanship’s facility. I have been informed of Reins of Rhythm Riding & Horsemanship’s Barn Rules and will adhere to them strictly. This agreement shall continue for each and every visit to Reins of Rhythm Riding & Horsemanship’s facility.

The terms of this release form shall be construed as the entire agreement and may not be altered, amended, or modified except in writing and signed by both parties. The terms of this release shall be governed by the laws of the Commonwealth of Pennsylvania.

**If under 18, the parent or guardian must read and sign the above, indicating his/her acceptance.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(participant)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(parent/guardian if minor)

* **Grant of Permission**

I/we the undersigned, (participant above named for, if minor, parents/guardians) hereby grant permission and authority to Reins of Rhythm Riding & Horsemanship,, its officers and authorized representatives to act for us in executing verbal instructions of if unable to contact us, to act for us in dealing with physicians, available ambulance companies and hospitals, to obtain prompt medical attention for the participant named above in the event of any perceived medical emergency. I hereby covenant and agree to release Reins of Rhythm Riding & Horsemanship, their officers, agents, and employee, and owners of any property concerned, and hold harmless from liability for any injury or damage which the rider may sustain while at Reins of Rhythm Riding & Horsemanship, or participating in any activity sponsored by Reins of Rhythm Riding & Horsemanship,, and from any liability connected with obtaining prompt medical attention for the participant named above.

**If under 18, the parent or guardian must read and sign the above, indicating his/her acceptance.**

Date: \_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Participant)

Date: \_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian; if minor)

Reins of Rhythm Riding & Horsemanship

P.O. Box 236

Scotland, PA 17254

Dear Health Care Provider:

Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(participant’s name) is interested in participating in our supervised riding and horsemanship program. In order to provide this service safely, Reins of Rhythm Riding & Horsemanship is requesting 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** | **Y** | **N** | **To What Degree** |
| Atlantoaxial Instability – Include Neurologic Symptoms |  |  |  |
| Coxa Arthrosis |  |  |  |
| Cranial Deficits |  |  |  |
| Heterotopic Ossification/ Mysositis Ossifcans |  |  |  |
| Joint subluxation/ dislocation |  |  |  |
| Osteoporosis |  |  |  |
| Pathologic Fractures |  |  |  |
| Spinal Joint Fusion/ Fixation |  |  |  |
| Spinal Joint Instability/ Abnormalities |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Neurologic** | **Y** | **N** | **To What Degree** |
| Hydrocephalus/ Shunt |  |  |  |
| Seizure |  |  |  |
| Spina Bifida/ Chiari II malformation/ Tethered Cord/ Hydromyelia |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical/ Psychological** | **Y** | **N** | **To What Degree** |
| Allergies |  |  |  |
| Animal Abuse |  |  |  |
| Cardiac Condition |  |  |  |
| Physical/Sexual/Emotional Abuse |  |  |  |
| Blood Pressure Control |  |  |  |
| Dangerous to self or others |  |  |  |
| Exacerbations of medical conditions |  |  |  |
| Fire Setting |  |  |  |
| Hemophilia |  |  |  |
| Medical Instability |  |  |  |
| Migranes |  |  |  |
| PVD |  |  |  |
| Respiratory Compromise |  |  |  |
| Recent Surgeries |  |  |  |
| Substance Abuse |  |  |  |
| Thought Control Disorder |  |  |  |
| Weight Control Disorder |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other** | **Y** | **N** | **To What Degree** |
| Age |  |  |  |
| Indwelling Catheters/ Medical Equipment |  |  |  |
| Medications (Side effects) |  |  |  |
| 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 contact the program at the above phone number.

Sincerely,

Patience Groomes

Program Director and PACTH Certified Instructor

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: + -

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate current or past special needs in the following systes/areas, including surgeries:

|  |  |  |  |
| --- | --- | --- | --- |
| **Other** | **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. I understand that Reins of Rhythm Riding & Horsemanship’s program will consider the medical information given against the existing precautions and contraindications.

Therefore, I refer this person to Reins of Rhythm Riding & Horsemanship for ongoing evaluation to

determine eligibility for participation.

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD DO NO PA Other: \_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License/UPIN Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Consent for Release of Information**

**Reins of Rhythm Riding & Horsemanship**

**P.O. Box 236**

**Scotland, PA 17254**

**Phone: 717-228-8037**

I herby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(person or facility)

To release information from the records of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_

(participant’s name)

The information is to be released to: Reins of Rhythm Riding & Horsemanship, P.O. Box 236,

Scotland, PA 17254 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

 Occupational 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 unless revoked, in writing, at my request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality Policy**

Reins of Rhythm Riding & Horsemanship

P.O. Box 236

Scotland, PA 17254

Phone: 717-228-8037

Reins of Rhythm Riding & Horsemanship recognizes a legal and ethical obligation to maintain

confidentiality of sensitive information it might receive about a rider. Reins of Rhythm Riding & Horsemanship shall preserve the right of confidentiality for all individuals in its program. Staff and

volunteers shall keep confidential all medical, social, referral, personal and financial information

regarding a person and his/her family. Anyone who works for, volunteers at, provides services to, or

participates in programs at Reins of Rhythm Riding & Horsemanship is bound to this policy. This

confidentiality policy applies to all full- and part-time staff, independent contractors, temporary

employees, volunteers, board members, participants and their families, and anyone connected with

Reins of Rhythm Riding & Horsemanship who could obtain this information either accidentally or

on purpose. Reins of Rhythm Riding & Horsemanship will not disclose information to outside

agencies or individuals without the consent of the rider and/or parent or legal guardian, except as

required by law. Unauthorized disclosures of confidential information will result in dismissal and/or

termination from Reins of Rhythm Riding & Horsemanship.

I understand that all information (written and verbal) about participants at facility is confidential and will not be shared with anyone without the express written consent of the

participant and their parent/guardian in the case of a minor, except as required by law. I understand and

will observe the confidentiality policy of the Reins of Rhythm Riding & Horsemanship program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (by parent or guardian, if a minor) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

***Reins of Rhythm Riding & Horsemanship Program Representative Signature.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name