

***Rider Application
Packet***



Maryland Therapeutic Riding, Inc.

P. O. Box 6477, Annapolis, MD 21401
410-923-1187 (phone) 410-923-1432 (fax)
www.horsethatheal.org



Participant's Application and Health History

To be completed by the participant or parent/legal guardian/caregiver

Participant: _____

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

Address: _____

Phone: _____ E-mail: _____

Work Phone: _____ Cell Phone: _____

Alternate Phone (specify): _____

Employer/School: _____

Occupation: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregiver: _____

Address (if different from above): _____

Phone (if different from above): _____

Grandparent(s) name and address: _____

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			

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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?)

PHOTO RELEASE

- I DO
 DO NOT

consent to and authorize the use and reproduction by _____ 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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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.

<p>Orthopedic Atlantoaxial Instability - include neurologic symptoms Coxa Arthrosis Cranial Deficits Heterotopic Ossification/Myositis Ossificans Joint subluxation/dislocation Osteoporosis Pathologic Fractures Spinal Joint Fusion/Fixation Spinal Joint Instability/Abnormalities</p> <p>Neurologic Hydrocephalus/Shunt Seizure Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia</p> <p>Other Age - under 4 years Indwelling Catheters/Medical Equipment Medications - i.e. photosensitivity Poor Endurance Skin Breakdown</p>	<p>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</p>
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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,

Executive Director
Maryland Therapeutic Riding, Inc.
P. O. Box 6477
Annapolis, MD 21401
410-923-1187



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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 AtlantoAxial 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			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the NARHA center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____



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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

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: _____

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 _____ 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.

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 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: _____ Consent Signature: _____

Client, Parent or Legal Guardian



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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: *Maryland Therapeutic Riding, Inc. (Operating Center)*

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 for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____



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Release of Liability

Name of Participant _____

Maryland Therapeutic Riding, Inc., (MTR) its officers, employees and agents will not be responsible for any damages to person, animal or property at the MTR riding center or its grounds, nor will they be responsible for any property lost or destroyed. The undersigned volunteer/rider/parent/guardian hereby releases MTR, its officers, employees and agents from any and all liability, claims and damages whatsoever (including costs, expenses and attorney's fees) that might result from damages, injuries, or losses to the person or property during, or in connection with, or arising out of any show, clinic, event or function, whether or not such damages, injuries or losses result directly or indirectly from the negligent act or omission of such released parties.

WARNING: UNDER MARYLAND LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM INHERENT RISKS OF EQUINE ACTIVITIES.

In exchange for the use of the property leased by MTR and other valuable consideration, I agree that my use of the premises and any animals, facilities, or equipment owned or leased by MTR is at my own risk and I further agree to indemnify and hold harmless MTR, their respective officers, employees, and agents from any and all suits, actions, or claims of any type arising from my use of the premises or participation in the equine activity of such use by my guest, whether or not such claims result directly or indirectly from the negligent act or omissions of the indemnified parties or otherwise.

I acknowledge that riding and involvement with horses is a high risk activity. I have read this agreement and fully understand its content.

PLEASE SIGN HERE: _____
 (Adult volunteer/rider or parent guardian of minor volunteer/rider)

 Date