Special Equestrians, Inc.

PO Box 61528
Fort Myers, FL 33906-1528
telephone: 239.226.1221
fax: 239.226.1279
email: spequestrians@gmail.com
website: www.specialequestrians.net

# Participant's Application and Health History

**GENERAL INFORMATION**

**Participant: _____**

**DOB:_____ Age:_____ Height:_____ Weight:_____ Gender: M___ F___**

**Local Address:_____**

**City: _____ State: _____ Zip: _____**

**Summer Address: _____**

**City: _____ State: _____ Zip: _____**

**Home Phone: _____ Cell Phone _____E-mail_____**

**Employer / School: _____Work Phone_____**

**Address: _____**

**Phone: _____**

**Parent / Legal Guardian/Caregivers: _____**

**Address (if different from above): _____**

**Phone: _____**

**Referral Source:_____**

**Phone: _____**

**How did you hear about the program? _____**

**Classes are offered on Tuesday and Thursday afternoons (3:15-6:15pm), and Wednesday and Saturday mornings (9am-12pm). Please indicate your 1st and 2nd choice for days/times.**

**First Choice: _____Second Choice_____**

**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 | | | |
| 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, sitting, walking, wheelchair/walker use, driving/bus riding)

_____
_____
_____
_____

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

_____
_____
_____
_____

**GOALS** (What would you (or your child) like to accomplish in the coming year?)

_____
_____
_____
_____

## Participant/Parent/Guardian

**►Signature_____◄ Date_____**

## PHOTO RELEASE

I _____ DO _____ DO NOT consent to and authorize the use and reproduction by Special Equestrians, Inc. 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.

## Participant/Parent/Guardian

**►Signature_____◄ Date_____**

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# SPECIAL EQUESTRIANS, INC.
# LIABILITY RELEASE FOR PARTICIPANTS

**PLEASE READ BEFORE SIGNING:**

**WARNING**: UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO, OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISK OF EQUINE ACTIVITIES.

THE UNDERSIGNED PARTICIPANT AND ANY SIGNING PARENT OR GUARDIAN HEREBY AGREES TO RELEASE SPECIAL EQUESTRIANS, INC., THEIR OFFICERS, DIRECTORS, EMPLOYEES, MEMBER OR AGENTS, AND THE OWNERS OR MANAGERS OF THE GROUNDS WHERE THE RIDING AND EQUINE ASSISTED ACITIVITES TAKE PLACE FROM ANY LOSS, DAMAGE, LIABILITY OR INJURY ARISING OUT OF OR RESULTING FROM THIS RIDING OR RIDER'S PARTICIPATION THEREIN, INCLUDING THE NEGLIGENT ACTS OR OMISSIONS OF THE MANAGEMENT OF SPECIAL EQUESTRIANS, INC., THEIR OFFICERS, DIRECTORS, EMPLOYEES, MEMBERS OR AGENTS, AND THE OWNERS OR MANAGERS OF THE GROUNDS WHERE THE RIDING AND EQUINE ASSISTED ACTIVIES ARE TAKING PLACE.

_____

**PARTICIPANT'S PRINTED NAME**

**►SIGNATURE_____◄ DATE_____**
**PARTICIPANT/PARENT/GUARDIAN**

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# Emergency Medical Treatment Form

**____ Participant ____ Volunteer ____ Staff**

Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + - Date: _____

Allergies: _____

Current medications: _____

In the event of an emergency, contact:_____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event that 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, Special Equestrians, Inc. will determine if emergency services should be contacted. The injured adult or legal guardian/parent has the right to refuse treatment from the emergency responders; however Special Equestrians will call for emergency medical treatment services, when it is deemed necessary by our staff.

In the event of needed emergency medical treatment, Special Equestrians will:

1. Secure and retain medical treatment and transportation if needed.
2. Release 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 "lifesaving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

**Date: _____ ►Consent Signature: _____**

**Participant, Volunteer, Staff, Parent or Legal Guardian**

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# Information for Physician

Dear Health Care Provider:

Your patient 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. You may use the back of the form, if necessary.

**PATIENT'S NAME** _____ **Date** _____

| **ORTHOPEDIC** | **COMMENTS** | **MEDICAL/PSYCHOLOGICAL** | **COMMENTS** |
|---|---|---|---|
| Atlantoaxial Instability | | Allergies | |
| Coxa Arthrosis | | Animal Abuse | |
| Cranial Deficits | | Cardiac Condition | |
| Heterotopic Ossification | | Physical/Sexual/Emotional Abuse | |
| Joint subluxation/dislocation | | Blood Pressure Control | |
| Osteoporosis | | Dangerous to self or others | |
| Pathologic Fractures | | Respiratory Compromise | |
| Spinal Joint Fusion/Fixation | | Fire Settings | |
| Spinal Joint Instability/Abnormalities | | Hemophilia | |
| | | Medical Instability | |
| **NEUROLOGIC** | | Migraines | |
| Hydrocephalus/Shunt | | PVD | |
| Seizure | | Substance Abuse | |
| Spina Bifida/ Chiari II Malformation/ Tethered Cord/ Hydromyelia | | Exacerbations of medical conditions (i.e. RA, MS) | |
| | | Weight Control Disorder | |
| **OTHER** | | Thought Control Disorders | |
| Age - under 4 years | | Recent Surgeries | |
| Medications - i.e. photosensitivity | | | |
| Poor Endurance | | | |
| Skin Breakdown | | | |
| Indwelling Catheters/Medical Equipment | | | |

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 (239) 226-1221.

Sincerely,

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# Participant's Medical History & Physician's Statement

Participant:_____DOB:_____Height:_____Weight:_____
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:_____
Spasticity or Rigidity: Y N _____
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.***

| SYSTEM / AREA | 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 | | | |

*****SIGN AND DATE THIS FORM BELOW *****

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:_____City:_____State:___Zip:

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

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# Physical/Occupational Therapy Evaluation

NAME_____DOB_____EVALUATION DATE_____

DIAGNOSIS_____DESCRIPTION_____

OTHER PERTINENT MEDIAL HISTORY_____

_____

MUSCLE STRENGTH: GROSS_____

SPECIFIC WEAKNESSES_____

JOINT ROM: GROSS_____

SPECIFIC LIMITATIONS_____

MUSCLE TONE:_____

BALANCE: SITTING_____STANDING_____

COORDINATION: GROSS MOTOR_____FINE MOTOR_____

REFLEX ACTIVITY: DEVELOPMENTAL_____

_____

TENDON REFLEXES_____

PAIN: CHARACTER_____LOCATION_____

CAUSED BY_____RELIEVED BY_____

SENSORY IMPAIRMENTS_____

PERCEPTUAL PROBLEMS_____

COMMUNICATION DIFFICULTIES_____

SKIN CONDITIONS_____

FUNCTIONAL ABILITIES: MOBILITY_____

TRANSFERS_____

ADDITIONAL SKILLS_____

PROBLEM LIST PLANS AND GOALS

1. _____
2. _____
3. _____
4. _____
5. _____

ADDITIONAL COMMENTS (Continue on back, if necessary):

_____

_____

_____

**Signature** _____R.P.T./R.O.T.