228 Sandpiper Drive Weatherford, Texas 76088 (817) 929-0020

Participant's Application & Health History

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:

	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?

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

PHOTO RELEASE

I ☐ DO

☐ DO NOT

consent to and authorize the use and reproduction by _____
(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

Signed in the presence of center staff

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Authorization for Emergency Medical Treatment Form

☐ Participant ☐ Staff ☐ Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____City_____State_____Zip_____

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 Stars & Strides Stables 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

Signed in presence of center staff

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

Signed in presence of center staff

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Release and Hold Harmless Agreement

I, _____ [Name of Participant], have the opportunity to participate in the Stars and Strides riding program at Stars and Strides Stables.

I understand that participating in equine activities, as a participant, rider, volunteer, student, spectator or staff, exposes me to a risk of property damage, personal injury or death. I understand that my choice of participating in equine activities is voluntary on my part, and I affirm my desire to participate in the program set out above. I agree to assume full responsibility for my safety and the safety of my property while I am in the arena or sensory trail, in transit to and from the arena or sensory trail and at all other times. I understand that I may sometimes participate in various activities, some of which may include an element of risk.

In consideration of being allowed to participate in the above mentioned activity, I, the undersigned, and my Parent/Guardian, if applicable, do hereby release, indemnify, and hold harmless the Miller family, Miller Ranch, Stars and Strides Stables and/or their Board of Directors, officers, agents, employees and volunteers, any allied health, mental health professionals and any other professionals volunteering and/or contracting with Stars and Strides Stables or any other equine activity sponsor as well as other participants and spectators from any and all liability claims, demands, and actions whatsoever arising out of or related to any loss, damage, or injury, including death, which may be sustained by me or to any property belonging to me. The terms hereof shall also serve as a release and assumption of risk for my heirs, executor and administrator, and for all members of my family, and may be pleaded as a bar to litigation. Jurisdiction of this matter and venue shall lie exclusively in Parker County, Texas.

WARNING

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN 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 am 18 years of age or above (or my Parent/Guardian is also a signatory herein) and have read this Release and Hold Harmless Agreement and understand and voluntarily accept the terms.

_____	_____	_____
Signature of Participant	Date	Print Name of Participant

PARENT/GUARDIAN

(This section must be completed if participant is under age 18 or legally incapacitated.)
By signing herein, I acknowledge that I have read, understand and voluntarily agree to accept the terms of the above Release and Hold Harmless Agreement with respect to the above named Participant.

_____	_____	_____
Signature of Parent/Guardian of Participant	Date	Print Name Parent/Guardian

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Patient's Medical History and 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: AltantoDens Interval X-rays, date:_____ Results: + -

Neurologic Symptoms of AltantoAxial Instability: _____

Please indicate current of past special needs in the following systems/areas, including surgeries:

	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	☐	☐	

To my knowledge, there is not reason why this person cannot participate in supervised, equestrian activities. However, I understand that the PATH, Int. 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: _____