



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:

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.

Signature: _____ Date: _____

Participant, Parent, Legal Guardian
(signed in the presence of center staff)

LIABILITY RELEASE

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

DATE
SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN



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 (medicines, food, environmental, insects, plants): _____

Current medications: _____

In the event of an emergency, contact:

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 Special Equestrians, Inc. 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: _____

Participant, 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 procedures to take place:

Date: _____ Non-Consent Signature: _____

Participant, Parent or Legal Guardian
Signed in presence of center staff



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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** _____

<u>ORTHOPEDIC</u>	<u>COMMENTS</u>	<u>MEDICAL/PSYCHOLOGICAL</u>	<u>COMMENTS</u>
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	
<u>NEUROLOGIC</u>		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	
<u>OTHER</u>		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,

Special Equestrians, Inc.



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Participant's Medical History & Physician's Statement Must be Completed Annually by a Physician

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: AtlantoDens Interval X-rays, Date: _____ Result: + --
Any Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. If yes, please comment.			
<u>SYSTEM / AREA</u>	<u>Y</u>	<u>N</u>	<u>COMMENTS</u>
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

*****PHYSICIAN MUST SIGN AND DATE THIS FORM BELOW *****

Given the above diagnosis and medical information, this person is not precluded from participation in equine assisted activities. However, I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ **Date:** _____

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

Phone: () _____ FAX: _____ **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.**