



Special Equestrians, Inc.

PO Box 61528 • Fort Myers, FL 33906-1528

Office Phone: 239-226-1221 • Fax: 239-226-1279

www.specialequestrians.net • se@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: _____

Phone: _____ Alternative #: _____ E-mail _____

Employer / School: _____

Address: _____

Phone: _____

Parent / Legal Guardian/Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

Person to contact in case of emergency _____ Phone: _____

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 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)

PHYCHO / 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 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



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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:

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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RELEASE OF LIABILITY

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 RIDER 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 TAKES 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 IS TAKING PLACE.

RIDER'S PRINTED NAME

RIDER'S SIGNATURE (PARENT OR GUARDIAN, IF UNDER 18)

DATE _____



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GUARDIAN/CUSTODIAN RELEASE OF LIABILITY AGREEMENT

THE UNDERSIGNED, AS LEGAL GUARDIAN/GUARDIANS OR CUSTODIAN/CUSTODIANS OF _____, FOR AND IN CONSIDERATION OF, THE AGREEMENT TO THE SPECIAL EQUESTRIANS, INC. TO PROVIDE RIDING INSTRUCTION TO SAID CHILD/ADULT, DOES HEREBY FOREVER RELEASE, ACQUIT, DISCHARGE, AND HOLD HARMLESS THE SPECIAL EQUESTRIANS, INC., ITS OFFICERS, TRUSTEES, AGENTS EMPLOYEES, REPRESENTATIVES, SUCCESSORS AND ASSIGNS, FOR THE MANNER OF CLAIMS, DEMANDS AND DAMAGES OF EVERY KIND AND NATURE WHATSOEVER, WHICH THE UNDERSIGNED OR SAID CHILD/ADULT MAY NOW, OR IN THE FUTURE HAVE AGAINST THE SPECIAL EQUESTRIANS, INC. ITS OFFICERS, TRUSTEES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS AND ASSIGNS ON ACCOUNT OF ANY PERSONAL INJURIES, PHYSICAL OR MENTAL CONDITION, KNOWN OR UNKNOWN, TO THE PERSON OF SAID CHILD/ADULT, AND THE TREATMENT THEREFORE AS A RESULT OF, OR IN ANY WAY GROWING OUT OF, THE ACTS OF THE SPECIAL EQUESTRIANS, INC. ITS OFFICERS, TRUSTEES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS AND ASSIGNS, INCLUDING BUT NOT LIMITED TO, THEIR NEGLIGENCE OR GROSS NEGLIGENCE, IN RENDERING THE SERVICES ABOVE DESCRIBED OR IN ANYWAY INCIDENTAL THERETO.

WARNING: UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR OR 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.

DATE: _____

SIGNED: _____

NAME OF CENTER: _____

WITNESSED: _____



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Participant's Medical History & Physician's Statement

Special Equestrians is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment, specially trained horses, and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each person is required to furnish the following medical information before being accepted as a rider.

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ City: _____ State: _____ Zip: _____ Parent/Guardian: _____
 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: + --
 Neurologic Symptoms of AtlantoAxial Instability: _____

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

<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			

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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Precautions and Contraindications to Equine Activities

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.

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

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

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

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,

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Partner Agency

Physical/Occupational Therapy Evaluation

NAME _____ DOB _____ EVALUATION DATE _____

DIAGNOSIS _____ DESCRIPTION _____

SURGERIES PERFORMED (WITH DATES) _____

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 _____

Physical/Occupational Therapy Evaluation-2

NAME _____

PROBLEM LIST

PLANS AND GOALS

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

ADDITIONAL COMMENTS:

_____ R.P.T./R.O.T.