Cloud Dancers Therapeutic Horsemanship Program, Inc.

Office use only:

Photo Release Y / N
Medical Consent Y / N

2019 Participant Application

Participant's Name: _____ DOB: _____ Today's Date: _____

Address (street) _____ (city) _____ (state) _____ (zip) _____ Phone: _____

Parent/Guardian's Name: _____ Phones: (H) _____ (C) _____ (W) _____

Email: _____ How did you hear about Cloud Dancers?_____

Please complete the following summary. Describe the participant's 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.)*

_____

_____

OTHER THERAPIES **(***Has the participant ever received any type of therapy such as Physical Therapy, Speech-Language Therapy, or Occupational Therapy? If yes, indicate which one(s) and when received.)*

_____

GOALS *(What would the participant/family/guardian(s) like to accomplish through this program?*) _____

_____

Please indicate availability:

___ Weekday ___ Morning

___ Weekend ___ Afternoon

___ Evening

How will you pay for lessons? (*check all that apply)*:

___ Private

___ Scholarship (*i.e. CTHF)*: _____

___ DD Waiver/Medicaid (i.e. Mi Via, Centennial Care): _____

___ Other _____

Authorization for Emergency Medical Treatment Form

Participant's Name: _____ Physician's Name: _____

Preferred Medical Facility: _____ Health Insurance Company: _____ Policy #: _____

Allergies: _____

Current medications: _____

IN THE EVENT OF AN EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PARENT/LEGAL GUARDIAN (*if applicable*):

Name: _____ Address: (street) _____ (city) _____ (state) _____ (zip) _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, while being on the property where the riding program operates, or in participating in other program activities, I authorize Cloud Dancers Therapeutic Horsemanship Program, 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.***

Select <u>one</u> of the plans below:

CONSENT Plan	**NON-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. Consent name (printed): _____ Individual or Parent/Legal Guardian Consent name Signature: _____ Date: _____	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 where the riding program operates. * 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: _____ _____ Non-Consent name (printed): _____ Individual or Parent/Legal Guardian Non-Consent name Signature: _____ *Signed in presence of center staff* Date: _____

Participant Liability and Photo Release Form

Liability Release (required)

The undersigned, a participant, or the undersigned, as parent(s) or guardian(s) of _____, a participant, for and in consideration of the agreement of Cloud Dancers Therapeutic Horsemanship Program, Inc. to provide equine assisted activities to said participant, does/do hereby forever release, acquit, discharge and hold harmless Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said rider may now, or in the future, have against Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said rider and the treatment therefore as a result of, or in any way growing out of, the acts of Cloud Dancers Therapeutic Horsemanship Program, Inc., its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Individual or Parent/Legal Guardian (print name): _____ **Signature**: _____ **Date**: _____

Photo/Media Release (optional)

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant to Cloud Dancers Therapeutic Horsemanship Program, Inc., permission to take or have taken, still or moving photographs and films including television picture of _____, a participant, of Cloud Dancers Therapeutic Horsemanship Program, Inc. I/we further consent and authorize Cloud Dancers Therapeutic Horsemanship Program, Inc., its advertising agencies, news media, and any other persons interested in Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work, to use and reproduce the photographs, films and pictures to circulate and publicize the same by all means including without the generality of the foregoing newspapers, web site, television media, brochures, pamphlets, instructional materials, books, and clinical material. With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) on this release other than the intention of Cloud Dancers Therapeutic Horsemanship Program, Inc. to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding Cloud Dancers Therapeutic Horsemanship Program, Inc., and its work. I/we understand that this permission is not restricted to the duration of time the above named participant is a registered participant in a Cloud Dancers Therapeutic Horsemanship Program. I/we further understand that I/we can reverse this permission at any time by submitting a written statement to that effect to Cloud Dancers Therapeutic Horsemanship Program, Inc., P.O. Box 14089, Albuquerque, NM 87191.

Individual or Parent/Legal Guardian (printed name): _____ **Signature**: _____ **Date**: _____

Cloud Dancers Therapeutic Horsemanship Program, Inc.
P.O. Box 14058 Albuquerque, NM 87191

The mission of Cloud Dancers Therapeutic Horsemanship Program, Inc., a non-profit corporation, is to empower individuals who are mentally, physically, emotionally or socially challenged through the use of PATH-approved equine experiences.

Date: _____

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 Participant's Medical History & Physician 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
Abuse
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Fire Settings
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifica/Chiari II malformation/Tethered Cord/Hydromyelia
Substance Abuse
Thought Control Disorders
Weight Control Disorders
Medications (i.e., photosensitivity)
Poor Endurance
Indwelling Catheters/Medical Equipment

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Skin Breakdown
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e.RA,MS)
Cardiac Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Thought Control Disorders
Recent Surgeries
Weight Control Disorders
Indwelling Catheters/ Medical Equipment
Other

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please feel free to contact the center at the address indicated above, or leave a message at 505-926-1426.

Sincerely,

Cloud Dancers Therapeutic Horsemanship Program, Inc.

Cloud Dancers Therapeutic Horsemanship Program, Inc.

Participant's Medical History & Physician's Statement

(MUST be completed by the applicant's **physician**.)

Participant _____ Today's Date _____ Height: _____ Weight: _____
Birthdate: _____ Gender: M ____ F ____

Cloud Dancers Therapeutic Horsemanship Program, Inc. is a recreational horseback-riding/ other equine assisted activities program designed to benefit its riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each participant is required to furnish the following medical information before riding or participating in the program.

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Psychological: _____

Allergies (to medications or other):

_____

Date of Tetanus Shot _____

Seizure Type: _____ Controlled? Y ____ N ____ Date of last seizure: _____

Shunt present? Y __ N ___ Date of last revision: _____

Special precautions/needs

_____

Current or Past Special Needs: Visual ___ Auditory ___ Neurologic ___ Muscular ___ Balance ___ Spasticity and/or Rigidity ___ Coordination ___ Circulatory ___ Cardiac ___ Pulmonary ___ Tactile Sensation ___ Integumentary/Skin ___ Immunity ___ Bones/Joint ___ Learning Disability ___ Cognitive ___ Behavioral ___Emotional/Psychological ___ Pain ___ Communication ___ Breathing ___ Digestion ___ Elimination___ Speech ___ Orthopedic ___ Allergies ___ Other _____

Mobility: Independent Ambulation Y ___ N ___ Assisted Ambulation Y ___ N ___ **Wheelchair** Y ___ N ___

Braces/Assistive Devices: _____

NOTE: FOR PERSONS WITH DOWN SYNDROME

DUE TO THE NATURE OF HORSEBACK RIDING, INIDIVIDUALS DIAGNOSED WITH DOWN SYNDROME CAN ONLY BE ACCEPTED INTO OUR PROGRAM WITH DOCUMENTED NEGATIVE INDICATION FOR ATLANTOAXIAL INSTABILITY. I CERTIFY THAT THE PATIENT NAMED ABOVE RECEIVED A COMPLETE NEUROLOGIC EXAM THAT REVEALS NO EVIDENCE OF ATLANTOAXIAL INSTABILITY OR DECREASE IN NEUROLOGIC FUNCTION. Please Initial _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation. In my opinion the above patient named can participate in equine assisted activities for a duration of 45 - 60 minutes under appropriate supervision.

Physician Name/Title (print): _____ MD DO NP PA Other _____

Physician Signature: _____ Date: _____

Physician Address: _____ Phone: _____

License/UPIN Number: _____