



Student Application

Please Email Completed Form to programs@clouddancersthp.org OR

Mail to PO Box 14058 Albuquerque, NM 87919

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

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

Parent/Legal Guardian's Name: _____

Phones: (H) _____ (C) _____ (W) _____ Email: _____

How did you hear about Cloud Dancers? _____

Please complete the below. Describe the student'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 student 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 student/family/legal guardian(s) like to accomplish through this program?)

Please indicate availability	Mon. - Fri.	Sat. - Sun.	Morning	Afternoon	Evening	Group Lesson	Private Lesson
How will you pay for lessons?	Private	DD Waiver/Medicaid (i.e. Mi Vida, Centennial Care)			CD Assistance	Other	

Student or Parent/Legal Guardian Signature: _____ Date: _____

Authorization for Emergency Medical Treatment

Student's Name: _____ Physician's Name: _____

Preferred Medical Facility: _____

Health Ins. Co.: _____ 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):

Parent/Legal Guardian's Name: _____

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

Phones: (H) _____ (C) _____ (W) _____

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 ONE of the Plans Below

CONSENT Plan

This authorization includes x-ray, surgery, medication, hospitalization, 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.

Consent Name (Print): _____
Student or Parent/Legal Guardian

Consent Name Signature: _____

Date: _____

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 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 (Print): _____
Student or Parent/Legal Guardian

Non-Consent Signature: _____ Date: _____



CLOUD DANCERS
THERAPEUTIC HORSEMANSHIP



Liability Release (Required)

The undersigned, a student, or the undersigned, as parent(s) or legal guardian(s) of _____, a student, for and in consideration of the agreement of Cloud Dancers Therapeutic Horsemanship Program, Inc. to provide equine assisted activities to said student, 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 student 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.

Student or Parent/Legal Guardian (Print): _____

Student or Parent/Legal Guardian 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 student, 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 student is a registered student 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.

Student or Parent/Legal Guardian (Print): _____

Student or Parent/Legal Guardian Signature: _____ **Date:** _____



Date: _____

Must be Completed by Student's Physician

The mission of Cloud Dancers Therapeutic Horsemanship Program, Inc., a non-profit corporation, is to provide equine-assisted activities to individuals with physical, developmental, emotional, and/or social need through innovative riding, vaulting and ground programs.

Dear Health Care Provider:

Your patient, _____ is interested in participating in supervised equine activities. In order to safely provide this service, Cloud Dancers requests that you complete/update the attached Student's Medical History & Physician Statement. 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.

- | | |
|---|---|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Medications (i.e., photosensitivity) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Animal Abuse | <input type="checkbox"/> Neurologic |
| <input type="checkbox"/> Atlantoaxial Instability - include neurologic symptoms | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Blood Pressure Control | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Pathologic Fractures |
| <input type="checkbox"/> Coxa Arthrosis | <input type="checkbox"/> Physical/Sexual/Emotional |
| <input type="checkbox"/> Cranial Deficits | <input type="checkbox"/> Poor Endurance |
| <input type="checkbox"/> Dangerous to self or others | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Exacerbations of medical conditions (i.e. RA, MS) | <input type="checkbox"/> Recent Surgeries |
| <input type="checkbox"/> Fire Settings | <input type="checkbox"/> Respiratory Compromise |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Heterotopic Ossification/Myositis Ossificans | <input type="checkbox"/> Skin Breakdown |
| <input type="checkbox"/> Hydrocephalus/Shunt | <input type="checkbox"/> Spina Bifida/Chiari II malformation/Tethered Cord/Hydrmyelia |
| <input type="checkbox"/> Indwelling Catheters | <input type="checkbox"/> Spinal Joint Fusion/Fixation |
| <input type="checkbox"/> Joint subluxation/dislocation | <input type="checkbox"/> Spinal Joint Instability/Abnormalities |
| <input type="checkbox"/> Medical Equipment | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Medical Instability | <input type="checkbox"/> Thought Control Disorders |
| <input type="checkbox"/> Medical/Psychological | <input type="checkbox"/> Weight Control Disorders |
| <input type="checkbox"/> Other: | |

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



Student's Medical History and Physician's Statement

Must be Completed by Student's Physician

Student's Name: _____ Height: _____ Weight: _____ Birthdate: _____ Gender: M / F

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Psychological: _____

Allergies (To Medications or Other): _____

Date of Tetanus Shot: _____ Seizure Type: _____ Date of Last Seizure: _____ Controlled: Y / N

Shunt Present: Y / N Date of Last revision: _____ Special Precautions/Needs: _____

Current or Past Special Needs:

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulatory | <input type="checkbox"/> Immunity | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Auditory | <input type="checkbox"/> Cognitive | <input type="checkbox"/> Integumentary/Skin | <input type="checkbox"/> Spasticity and/or Rigidity |
| <input type="checkbox"/> Balance | <input type="checkbox"/> Communication | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Coordination | <input type="checkbox"/> Muscular | <input type="checkbox"/> Tactile Sensation |
| <input type="checkbox"/> Bones/Joint | <input type="checkbox"/> Digestion | <input type="checkbox"/> Neurologic | <input type="checkbox"/> Visual |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Elimination | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Emotional/Psychological | <input type="checkbox"/> Pain | |

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, INDIVIDUALS 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 NEUROLOGICAL FUNCTION. Please initial: _____

Given the diagnosis and medical information, this individual is not medically precluded from participation in equine assisted activities. I understand that Cloud Dancers will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this individual to Cloud Dancers for ongoing evaluation to determine eligibility for participation. In my opinion the above patient 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: _____ Date: _____

Physician Signature: _____ License/UIP Number: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____