Office Use Only

Photo Release
Medical Consent
Liability Release

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:** ________________

CD Staff Initials:_________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

CD Staff Initials: __________ Date: __________

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:** ____________________

CD Staff Initials: ___________ 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.

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

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.

CD Staff Initials: __________ Date: __________

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:

- ☐ Allergies
- ☐ Auditory
- ☐ Balance
- ☐ Behavioral
- ☐ Bones/Joint
- ☐ Breathing
- ☐ Cardiac
- ☐ Circulatory
- ☐ Cognitive
- ☐ Communication
- ☐ Coordination
- ☐ Digestion
- ☐ Elimination
- ☐ Emotional/Psychological
- ☐ Immunity
- ☐ Integumentary/Skin
- ☐ Learning Disability
- ☐ Muscular
- ☐ Neurologic
- ☐ Orthopedic
- ☐ Pain
- ☐ Pulmonary
- ☐ Spasticity and/or Rigidity
- ☐ Speech
- ☐ Tactile Sensation
- ☐ Visual
- ☐ 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, 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 NEUROLOGIVAL 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/UPI Number:** ___________________ **Phone:** _________________

Physician's Address: ____ **City**: ____________ **State**: _____ **Zip**: _________

CD Staff Initials: __________ Date: __________