



## Participant Application and Health History

### GENERAL INFORMATION

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis or Challenge: \_\_\_\_\_

Referral Source (Indicate Mental Health Professional, School Professional, Social Worker, PT or OT, etc...): \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Parent/Legal Guardian name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Caregiver name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

In Case of Emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Goals (what would you like to accomplish through participation in equine activities?):

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

Goal 3: \_\_\_\_\_

### HEALTH HISTORY

Physical Function (include mobility, assistive devices, orthotics, etc...): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emotional/Social/Behavior (Include any emotional, social or behavior issues that affect daily function): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Seizures (include type, frequency and method of control): \_\_\_\_\_

Medications (include any medications that may have a side effect that would affect equestrian activities): \_\_\_\_\_

**Please indicate current or past considerations in the following areas:**

		Y	N	If YES please explain
<b>Allergies</b>	Hay, dust, dander			
<b>Anxiety</b>	High anxiety, triggers			
<b>Assistive Mobility devices</b>	Wheelchair, cane, walker			
<b>Behavioral</b>	Aggression, defiance			
<b>Breathing</b>	Asthma, oxygen			
<b>Circulation</b>	Varicose veins, hemophilia, reduced circulation			
<b>Cognitive</b>	Ability to follow 1 to multi-step instructions			
<b>Communication</b>	ASL, speech delays, gesture			
<b>Digestion</b>	Gastronomy tube			
<b>Elimination</b>	Catheters, colostomy, incontinence			
<b>Emotional/ Mental Health</b>	Depression, anxiety, suicidal			
<b>Heart</b>	Surgeries, implants			
<b>Hearing</b>	Hearing aids, implants			
<b>Muscular</b>	Weakness, high tone, low tone			
<b>Neurologic</b>	Seizures, ataxias, tremors			
<b>Pain</b>	Over- or under- sensitive, headaches, joint pain			
<b>Past Surgeries</b>	Back, hip, heart, other			
<b>Triggers</b>	Factors that may initiate a negative behavior or response			
<b>Sensation</b>	Over- or under- sensitive			

Please provide any additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHOTOGRAPHY / AUDIOVISUAL RELEASE**

Participant Name: \_\_\_\_\_

I DO \_\_\_\_\_

I DO NOT \_\_\_\_\_

Grant Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center permission to take or have taken still or moving photographs or other audiovisual material and authorize the Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center to reproduce said photographs and use them for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent or guardian if participant is under 18)*

**Participant's Consent for Release of Information**

I hereby authorize the referring specialist or any other specialists involved with the participant to release information for the purpose of developing the most beneficial equestrian program. The information that may be asked to be released is indicated below:

- Medical history
- Physical therapy assessment, evaluation and program plan
- Speech therapy assessment, evaluation and program plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-behavioral management plan
- Other: \_\_\_\_\_

This release is valid indefinitely and can be revoked, in writing, at my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent or guardian if participant is under 18)*

## Release of Liability

I, the undersigned, for myself and/or on behalf of my child warrant and agree that I will make no claim or file suit for any injury to person or property, or for any loss or destruction of any article of any kind or nature in connection with the participation of me and/or child at the Swiftsure Ranch and/or participation in the programs of the Swiftsure Ranch Therapeutic Equestrian Center. I understand that neither the Swiftsure Ranch nor Swiftsure Ranch Therapeutic Equestrian Center nor their respective officers, directors, employees, volunteers or agents accept any responsibility for accidents, damage, injury or illness to the riders, horses, members, sponsors, agents, spectators or any other person or property owner in connection with operation of the Swiftsure Ranch. As a condition of using the facilities of the Swiftsure Ranch and the programs of Swiftsure Ranch Therapeutic Equestrian Center, I hereby waive, on my own behalf and/or for my child, all claims arising out of any act or omission of the Swiftsure Ranch and/or Swiftsure Ranch Therapeutic Equestrian Center and their respective officers, directors, employees, volunteers and agents. I understand that there are inherent risks in any participation and those risks are assumed by me for myself and/or on behalf of my child. I fully understand that animals and conditions are unpredictable and that the risk of injury or death is inherent to the activity of equine-assisted activities and therapies. For myself and/or on behalf of the child, I fully assume the responsibility for the risk of injury or death caused by my and/or the child's contact with horses and horseback riding. I, and/or on behalf of the child, completely release Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center and their respective officers, directors, employees, volunteers and agents from any and all liability for any and all injuries or death to either of me and/or to the child caused by my and/or child's contact with horses and/or horseback riding. Signing of this form binds me and/or my child to this hold harmless agreement. This document shall be constructed under the laws of the State of Idaho.

Participant's Name: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If participant is under 18)*

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