Participant Application and Health History

GENERAL INFORMATION

Participant Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Primary Phone: _____ Alt. Phone: _____ Email: _____

Employer/School: _____

Parent/Legal Guardian(s): _____

Address (if diff from above): _____

Phone (if diff from above): _____ Email: _____

Caregiver(s): _____

Address (if diff from above): _____

Phone (if diff from above): _____ Email: _____

Referral Source: _____ Phone: _____

How did you hear about our program? _____

HEALTH HISTORY

Primary Diagnosis:_____ Date of Onset: _____

Secondary Diagnosis: _____ Date of Onset: _____

Current or past seizures? Y N If yes, please elaborate type, frequency, and method of control:

_____

_____

_____

Medications (include prescription and over-the-counter; name, dose and frequency):_____

_____

_____

Past surgeries? Please explain_____

_____

_____

Recent imaging studies (x-ray, MRI, CT scan, etc.) _____

_____

Please indicate current or past considerations in the following areas (left-hand column gives area, right hand column gives examples of important information to include): *(Use separate sheet if necessary)*

		Y	N	If YES please explain
Vision	Glasses/contacts			
Hearing	Hearing aids, implants			
Sensation	Over- or under- sensitive			
Communication	ASL, speech delays, gesture			
Heart	Surgeries, implants			
Breathing	Asthma, oxygen			
Digestion	Gastronomy tube			
Elimination	Catheters, colostomy, incontinence			
Circulation	Varicose veins, hemophilia, reduced circulation			
Emotional/ Mental Health	Depression, anxiety			
Behavioral	Aggression, defiance			
Pain	Over- or under- sensitive, headaches, joint pain			
Bone/Joint	Spinal surgeries, fusions, implants, osteoporosis, arthritis			
Muscular	Weakness, high tone, low tone			
Neurologic	Seizures, ataxias, tremors			
Cognitive	Ability to follow 1 to multi-step instructions			
Allergies	Hay, dust, dander			

The following conditions, if present, may represent **precautions** or **contraindications** to equine-assisted activities. Please note whether these conditions are present, and to what degree.

YES	NO	CONDITION	Orthopedic
□	□	Spinal Fusion	
□	□	Spinal Instabilities/Abnormalities	
□	□	Atlantoaxial Instabilities	
□	□	Scoliosis	
□	□	Kyphosis	
□	□	Lordosis	
□	□	Hip Subluxation and Dislocation	
□	□	Osteoporosis	
□	□	Pathologic Fractures	
□	□	Coxas Arthrosis	
□	□	Heterotopic Ossification	
□	□	Osteogenesis Imperfecta	
□	□	Cranial Deficits	
□	□	Spinal Orthoses	
□	□	Internal Spinal Stabilization Devices (such as Harrington Rods)	

Neurological

□	□	Hydrocephalus/shunt
□	□	Spina Bifida
□	□	Tethered Cord
□	□	Chiari II Malformation
□	□	Hydromyelia
□	□	Paralysis due to Spinal Cord Injury (above T-9)
□	□	Uncontrolled Seizure Disorders

Medical/Surgical

□	□	Allergies to Grasses, Animals and Dust
□	□	Cancer
□	□	Poor Endurance
□	□	Recent Surgery
□	□	Diabetes
□	□	Peripheral Vascular Disease
□	□	Varicose Veins
□	□	Hemophilia
□	□	Hypertension
□	□	Serious Heart Condition

□ □ Stroke (Cerebrovascular Accident)

Secondary Concerns

□ □ Behavior Problems
□ □ Age less than two years
□ □ Age two – four years
□ □ Acute exacerbation of chronic disorder
□ □ Indwelling catheter

If you checked **YES** to any of the above, please explain: _____

_____

_____

_____

Describe the participant's abilities in the following areas:

PHYSICAL FUNCTION (include mobility skills such as use of assistive devices and transfers, orthotics worn and purpose)

_____

_____

_____

PSYCHO/SOCIAL FUNCTION (include daily activities such as work or school - including grade completed, leisure interests, relationships, family structure, support system, companions and animals, fears)

_____

_____

_____

GOALS (What would you like to accomplish through participation in equine-assisted activities? Feel free to include other therapy goals and IEP objectives)

_____

_____

_____

Signature: _____ **Date:** _____

(Parent/Guardian if participant is under 18)

SWIFTSURE RANCH

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: _____

Authorization for Emergency Medical Treatment

Participant Name: _____ DOB: _____

Preferred medical facility: _____

Health insurance company: _____ Policy #: _____

Family physician: _____ Phone: _____

Allergies: _____

Current medications (prescription and over-the-counter): _____

_____

Other pertinent medical information about you or your child in case of an emergency:

_____

_____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

_____ **I CONSENT** for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the Swiftsure Ranch property. I authorize Swiftsure Ranch Therapeutic Equestrian Center to: (1) Secure and retain medical treatment and transportation if needed, and (2) Release client records upon request to the authorized individual or agency involved in emergency medical treatment. I release the Swiftsure Ranch and Swiftsure Ranch Therapeutic Equestrian Center staff from any and all liability for any decision made in regard to my child's or my injury, care or hospitalization.

_____ **I DO NOT CONSENT** for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the Swiftsure Ranch property.

- **Parent or guardian MUST remain on site at all times during equine-assisted activities.**

Signature: _____ Date: _____

(Parent or guardian if participant is under 18)

Media Waiver

Participant Name: _____

I DO _____

I DO NOT _____

Authorize Swiftsure Ranch Therapeutic Equestrian Center permission to use photos, videos, verbal or written feedback about the program and experiences with the program. I understand this information may be used in written or electronic form including social media for publications, promotional literature, grant writing purposes, education or any others use for the benefit of the program.

Signature: _____ Date: _____

(Parent/guardian if participant is under 18)

Swiftsure Ranch Therapeutic Equestrian Center
114 Calypso Lane, Bellevue, Idaho 83313 Phone:
208.578.9111• Fax: 208.788.0259
kristy@swiftsureranch.org

Participant's Consent for Release of Information

I hereby authorize: _____
(physician, therapist, teacher, etc.)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to Swiftsure Ranch Therapeutic Equestrian Center.

For the purpose of developing an equine activity program for the above named participant, the information 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)

Print Name: _____

Relation to Participant: _____