Horsin' Around

501(C)3 Non-Profit Organization
Equine-Assisted Activities, Therapies, and Equine Services for Heroes
1032 John Carter Road, Bloomingdale, Ga 31302 * www.horsinaround.org * 912-748-7917

Participant Application and Health History

General Information

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Gender: M F Race *(demographic purposes only)*: _____

Address: _____

Phone: _____ Alternative #: _____

Email: _____

Best Means of Contact: Call Text Email

Employer/School: _____

Address: _____

Phone: _____

Parent(s)/Legal Guardian(s): _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

PHOTO RELEASE

I DO / DO NOT consent to and authorize the use and reproduction by Horsin' Around of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Participant, Parent or Legal Guardian

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Health History

Diagnosis: _____ Date of Onset: _____

Please Indicate current or past special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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

Describe your 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/riding bus)

PSYCHO/SOCIAL FUNCTION (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc)

GOALS (i.e., Why are you applying to participate? What would you like to accomplish?)

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Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Horsin' Around 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

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.

Date: _____ Consent Signature: _____

(Client, Parent or Legal Guardian)

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness o injury during the process of receiving services or while being on the property of he agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Consent Signature: _____

(Client, Parent or Legal Guardian)

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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 Medical History an Physician's 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
Heterotopic Ossiffication/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractions
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida
Chiari II Malformation
Tethered Cord
Hydromyelia

Other
Age - under 4 years
Indwelling Catheters
Medications - i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
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 feel free to contact the center at the address/phone indicated above.

Sincerely,

Erin Dunn, DPT, PT
President
PATH Int Registered Instructor

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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

_____

_____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

_____

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

Braces/Assistive Devices: _____

_____

_____

For those with Down's Syndrome: AtlantoDens Interval x-rays, date: _____ Result: + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			

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Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning			
Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the PATH Intl center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/ limitations by a licensed/credentialed health professional (e.g., PT, OT, SPL, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

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Clark's Riding Lessons & Trail Rides, Inc
Release of Liability & Hold Harmless Agreement
Acknowledgement of Risk & Acceptance of Responsibility

I recognize that there is a significant element of risk in any adventure, sport of activity associated with the outdoors. Knowing of the inherent risk, danger and rights involved in the activities, I certify that myself and my family, including any minor children, are fully capable of participating in the activities.

I assume full responsibility of my family, visitors, invitees and myself, including any minor children, for bodily injury, death, loss of personal property and expenses thereof.

This a a release, hold harmless and indemnification of the undersigned in favor of Judith A. Clark, Gary L. Clark for Clark's Riding Lessons & Trail rides, Inc. and Horsin' Around, Inc. and/or their agents, family and employees shall constitute the best evidence of my agreement of offered as evidence in any court proceeding.

I, _____ , have read and understand fully the agreement above.

Signature: _____

Date: _____

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Clark's Riding Lessons and Trail Rides, Inc.
Waiver and Release of Liability and Hold Harmless Agreement
Acknowledgement and Assumption of Risk and Acceptance of Responsibility

WARNING: UNDER GEORGIA LAW, AN EQUINE ACTIVITY SPONSOR OR EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO CHAPTER 12 OF TITLE 4 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED.

In consideration for myself, my children and/or other minors for whom I have legal responsibility (my children and such other minors are collectively referred to herein as "my children") being permitted to volunteer with or otherwise participate in the recreational and/or therapeutic horseback riding programs, services, lessons, trail rides and/or other equine activities (the "Programs") provided by and through Horsin' Around, Inc, Gary L. Clark, Judith A. Clark, and Clark's Riding Lessons and Trail Rides, Inc. ("Horsin' Around), as well as my and/or my children's use of any equipment, property (real or personal) or facilities owned or provided by Horsin' Around and/or by any private landowner(s) who permit Horsin' Around to use their property, which consists of pastoral, rugged land, in connection with the Programs (the "Landowners") (Horsin' Around and the Landowners are collectively referred to herein as the "Releasees"), I agree as follows:

I understand and acknowledge that there are inherent risks, hazards and dangers associated with equine activities, which include, but are not limited to, the risk of serious bodily injury, disability, or death resulting from kicks, bites, or other physical contact with horses; falling off of a horse; being thrown from a horse; having a horse fall on, step on, or run into a rider or other program participant; being dragged by a horse if one's foot/hand/limb gets caught in the stirrups or other tack/riding equipment; failure or breakage of tack/riding equipment; and/or collision with other horses, riders, program participants, trees, buildings, structures, vehicles, and/or other objects. I understand and acknowledge that these risks may arise from foreseeable or unforeseeable circumstances, and may arise from negligence of owners, officers, employees, instructors, therapists, volunteers, or agents of the Releasees; the negligence of other riders or program participants; the negligence of other persons or parties not affiliated with the Releasees; accidents; breaches of contract; the forces of nature and/or other causes.

Although I am aware of and fully appreciate these risks, I believe that the potential benefits that myself, my family and/or my children my obtain from participating in the Programs are greater than the risks and potential risks assumed. by and through my or my children's participation in the Programs, I hereby assume all risks and dangers of, and accept all responsibility for, any and all injuries, disabilities, death, loss or damage which arise out of or relate in any way to my or my children's participation in the Programs, and/or my children's use of any equipment, property (real or personal) or facilities owned or provided by the Releasees in connection with the Programs, whether causes in whole or part by the

negligence of the owners, officers, employees, instructors, therapists, volunteers, or agents of the Releasees or by any other person or entity.

Pursuant to such assumptions of risk, I, on behalf of myself, my family members, my children, and our respective personal representatives, heirs, administrators, executors, successors or assigns, hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify the Releasees and their respective owners, officers, employees, instructors, therapists, volunteers, or agents from and against any and all past, present and future claims, actions, causes of action, suits, demands and damages for bodily/personal injury, wrongful death, loss of services or other claims or causes of action, arising out of or relating in any way to my or my children's participation in the Programs, and/or my or my children's use of any equipment, property (real or personal) or facilities owned or provided by the Releasees in connection with the Programs. Additionally, I, on behalf of myself, my family members, my children, and our respective personal representatives, heirs, administrators, executors, successors or assigns, agree and covenant not to sue the Releasees for any past, present and future claims, actions, causes of action, suits, demands and damages for bodily/personal injury, wrongful death, loss of service or other claims or causes of action, arising out of or relating in any way to my or my children's participation in the Programs, and/or my or my children's use of any equipment, property (real or personal) or facilities owned or provided by the Releasees in connection with the Programs.

I acknowledge and understand that Horsin' Around requires all riders/participants to wear a helmet when participating in the Programs. _____ (initials of participant/guardians)

I acknowledge that I have read this Waiver and Release of Liability and Hold Harmless Agreement, I fully understand it's terms, I understand that I have given up substantial rights by signing it, and I sign it freely and voluntarily without any inducement, undue influence or duress.

Date: _____

Print Name of Participant: _____ Age: _____ Date of Birth: _____

Signature of Participant: _____ Address: _____
(if participant is 18 years old or older)

Signature of Parent/Guardian: _____ Phone Number: _____
(if participant is less than 18 years old)

Signature of Parent/Guardian: _____ Phone Number: _____
(if participant is less than 18 years old)

*** **Please note that all parents/legal guardians must sign the Waiver and Release of Liability and Hold Harmless Agreement**