

Participant Application and Health History

Stoneybrook Foundation Therapeutic Riding Center
260 Mountain Trails Lane
Acme, Pa 15610 Phone:
(724) 613-3312

(To be completed by the participant or parent/legal guardian)

GENERAL INFORMATION

Participant Name: _____

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

What email should we send your invoice to: _____

Address: _____

(1) Home-Phone: _____ Mobile-Phone: _____ Email: _____

(2) Home-Phone: _____ Mobile-Phone: _____ Email: _____

Employer/School: _____

Parent/Legal Guardian: (if applicable) _____

Relationship to Participant _____

Address (if different from above): _____

(1) Home-Phone: _____ Mobile-Phone: _____ Email: _____

(2) Home-Phone: _____ Mobile-Phone: _____ Email: _____

Caregiver: (if applicable) _____ Phone #: _____

How did you hear about the program? _____

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			

MEDICATIONS (include prescription, over-the-counter; name, dose, 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/bus riding)

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 for participation? What would you like to accomplish?)

Signature: _____ Date: _____

Emergency Contact Information

Name: _____ DOB: _____

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Alternative Phone: _____

Name: _____ Relationship: _____ Phone: _____

Alternative Phone: _____

Photo Release

I ☐ DO

I ☐ DO NOT

Consent to and authorize the use and reproduction by Stoneybrook Foundation Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional materials, educational activities, exhibitions or for any other use for the benefit of the Center, and I give all rights to the photographs to the Center for its use.

Signature: _____ Date: _____

(Parent or Guardian, if a minor)

STUDENT RELEASE AND HOLD HARMLESS AGREEMENT

Inherent Risks of Equine Activities

Anyone who participates in any kind of activities on or about horses, including riding, training, assisting in medical treatment of horses, driving or being a passenger on a horse, or assisting a participant in a horse show or assisting show management, but does not include merely being a spectator to an equine activity, is considered to be engaged in an equine activity.

Equine activities hold inherent risks, defined by statute to include:

(1) the propensity of horses to behave in ways that may result in injury, harm, or death to persons on or around them; (2) the unpredictability of a horse's reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals; (3) certain hazards such as surface and subsurface conditions; (4) collisions with other horses or objects; (5) the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his or her ability.

Acknowledgement of Risk

I, _____, acknowledge that I have read the above statements and definitions, and hereby indemnify and hold harmless STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER, their employees or owners from any liability arising from accident, injury, theft, or damages to myself, my representatives, and helpers, all equipment and property, and all animals under my jurisdiction. I understand that I must wear a helmet, secured with a harness, at all times when mounted at Stoneybrook Foundation Therapeutic Riding Center. I have been informed of STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER's Barn Rules and Policies and Procedures and will adhere to them strictly. This agreement shall continue for each and every visit to STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER's property.

The terms of this release form shall be construed as the entire agreement and may not be altered, amended, or modified except in writing and signed by both parties. The terms of this release shall be governed by the laws of the Commonwealth of Pennsylvania.

If the participant is under 18, the parent or guardian must read the above and sign, indicating his/her acceptance.

Date: _____ Signed: _____
(Participant)

Date: _____ Signed: _____
(Parent/Guardian if minor)

Grant of Permission

I/we the undersigned, (participant above named for, if minor, parents/guardians) hereby grant permission and authority to STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER, its officers and authorized representatives to act for us in executing verbal instructions if unable to contact us, to act for us in dealing with physicians, available ambulance companies and hospitals, to obtain prompt medical attention for the participant named above in the event of any perceived medical emergency. I hereby covenant and agree to release STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER, their officers, agents, employees, and owners of any property concerned, and hold harmless from liability for any injury or damage which the rider may sustain while at STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER, or participating in any activity sponsored by STONEYBROOK FOUNDATION THERAPEUTIC RIDING CENTER, and from any liability connected with obtaining prompt medical attention for the participant named above.

If the participant is under 18, the parent or guardian must read the above and sign, indicating his/her acceptance.

Date: _____ Signed: _____
(Participant)

Date: _____ Signed: _____

(Parent/Guardian if minor)

Confidentiality Policy

Stoneybrook Foundation Therapeutic Riding Center recognizes a legal and ethical obligation to maintain confidentiality of sensitive information it might receive about a rider. Stoneybrook Foundation Therapeutic Riding Center shall preserve the right of confidentiality for all individuals in its program. Staff and volunteers shall keep confidential all medical, social, referral, personal and financial information regarding a person and his/her family. Anyone who works for, volunteers at, provides services to, or participates in programs at Stoneybrook Foundation Therapeutic Riding Center is bound to this policy. This confidentiality policy applies to all full- and part-time staff, independent contractors, temporary employees, volunteers, board members, participants and their families, and anyone connected with Stoneybrook Foundation Therapeutic Riding Center who could obtain this information either accidentally or on purpose. Stoneybrook Foundation Therapeutic Riding Center will not disclose information to outside agencies or individuals without the consent of the rider and/or parent or legal guardian, except as required by law. Unauthorized disclosures of confidential information will result in dismissal and/or termination from Stoneybrook Foundation Therapeutic Riding Center.

I understand that all information (written and verbal) about participants at this PATH, Intl. center is confidential and will not be shared with anyone without the express written consent of the participant or their parent/guardian, in the case of a minor, except as required by law. I understand and will observe the confidentiality policy of Stoneybrook Foundation Therapeutic Riding Center.

Signature

Date

Signature (by parent or guardian, if a minor)

Date

Print Name

Stoneybrook Foundation Therapeutic Riding Center
260 Mountain Trails Lane
Acme, Pa 15610 Phone:
(724) 613-3312

Date: _____

Dear Health Care Provider:

Your patient, _____
(Participant's name)

is interested in participating in supervised equine activities.

In order to safely provide this service, Stoneybrook Foundation Therapeutic Riding Center requests that you complete/update the attached Medical History and 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 Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
(i.e. RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact me at the address/phone indicated above.

Sincerely,

Rachel Cunningham
Executive Director

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: _____

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

Braces/Assistive Devices: _____

For those with Down Syndrome: Neurological Symptoms of Atlanto Axial Instability ☐ Present

☐ Absent

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

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities. I understand that Stoneybrook Foundation Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Stoneybrook Foundation Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

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

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____