For office use only
Referral:

Payment Code:

The Equestrian Therapy Program

Participantôs Information & Health History

*to be completed by participant or parent/guardian/caregiver

Participant's Name: _____

Address:_____City:_____State:_____Zip: _____

Phone:_____Cell: _____

Parent/Guardian/Caregiver Name: _____

Parent/Guardian address (if different from above):_____

Phone:_____

Primary Diagnosis:_____Date of Onset:_____

Secondary Diagnosis:_____Date of Onset:_____

DOB:_____Height:_____Weight:_____

Gender: M F

Medications:_____Allergies:_____

Health History

Please indicate if the student has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Hearing			
Vision			
Communication			
Balance			
Coordination			
Spasticity/Rigidity			
Muscular			
Neurological			
Orthopedic (Bone/Joint)			
Heart/Circulation			
Sensation			
Pain			
Incontinence			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
History of Animal Abuse			

Mobility: **Independent Ambulation**: Yes No **Crutches**: Yes No **Braces**: Yes No **Wheelchair**: Yes No

Walker: Yes No **Cane:** Yes No

Describe any medical condition requiring special precautions or treatment and medications and dosage:_____.

Signature: _____

The Equestrian Therapy Program

Emergency Medical & Consent Form

Participant's Name: _____

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

Physicianôs Name:_____Phone: _____

Address:_____City:_____State:_____Zip: _____

Preferred Medical Facility: _____

Health Insurance Co._____Policy # _____

Person who is authorized to give temporary assistance or care in the absence of parent or guardian:

Name:_____Phone:_____Relation: _____

Consent

In case of medical emergency, the undersigned authorizes ***Equestrian Therapy Program*** to provide such medical assistance as they determine to be necessary,

I hereby give my consent, in the event that all reasonable attempts to contact me have been unsuccessful, to the administration of any treatment deemed necessary by or the transfer to the student to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity to such surgery and are obtained prior to the performance of such surgery.

Date:_____Consent Signature: _____
(Participant if over 18, Parent/Legal Guardian)

Witness: _____ _____
(Parent/Legal Guardian)

Participants under age (18) must have this form signed either by both natural parents, or by the sole parent having legal custody, or by the participantôs legal guardian.

Non Consent

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 or The Equestrian Therapy Program.

__ 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 procedure to take place.

_____

Date: _____ Non-Consent Signature: _____
(Participant if over 18, Parent/Legal Guardian)

Witness: _____ _____
(Parent/Legal Guardian)

Participants under age (18) must have this form signed either by both natural parents, or by the sole parent having legal custody, or by the participantôs legal guardian.

EXPRESS ASSUMPTION OF RISK, RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT (Adult)

This Express Assumption of Risk, Release of Liability and Waiver of Claims (the ñAgreementò) is entered into by the undersigned, (the ñParticipantò as stated above), in favor of The Equestrian Therapy Program and their employees and independent contractors, (ñProvidersò). In consideration for being permitted to participate in Equine Activities including, but not limited to equine assisted psychotherapy and learning activities and otherwise handling equines, I acknowledge and agree as follows:

1)**Dangerous Activity:** I acknowledge that horses, ponies, and other equines can be unpredictable animals and fully realize that there are dangers and risks inherent in Equine Activities, including but not limited to:
a. The propensity of an equine to behave in ways that may result in injury, death, or loss to persons on or around the equine;

b. The unpredictability of an equineôs reactions to sounds, sudden movement, unfamiliar objects, persons or other animals;

c. Hazards, including but not limited to surface or subsurface conditions or weather;

d. A collision with another equine, another animal, a person or an object; and

e. The potential of an Equine Activity Participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the Participant or to other persons, including but not limited to, failing to maintain control over an equine or failing to act within the ability of the Participant.

I understand that neither the actions of any person, nor the actions of any animal can necessarily be controlled, and that my safety and that of my property cannot be guaranteed while participating in Equine Activities.

I also acknowledge that I have had the opportunity to inspect the equipment and real property of Providers and find the same to be acceptable.

I further acknowledge that I have sufficient ability to engage in Equine Activities of the kind provided by Providers.

2)**Assumption of Risks:** Understanding the risks involved, I voluntarily choose to participate in Equine Activities and EXPRESSLY ASSUME THE ASSOCIATED RISKS, INCLUDING THERISK OF INJURY AND DEATH, WHETHER CAUSED BY THE UNINTENTIONALNEGLIGENCE OF THE STABLE OR ANY OTHER CAUSE. I accept full and complete responsibility for my safety as well as that of any guests or observers that may accompany me to an Equine Activity, and for the safety of our personal property.

3)**Release and Waiver of Claims:** On behalf of myself, my heirs, successors in interest, personal representatives and assigns, I HEREBY RELEASE AND FOREVER DISCHARGE THESTABLE FROM ALL CLAIMS, ACTIONS, DEMANDS, RIGHTS, CAUSES OF ACTION AND LIABILITY, IN LAW OR IN EQUITY, BASED UPON ANY BODILYINJURY OR DISABILITY, ILLNESS OR DISEASE, DEATH, FINANCIAL LOSS, PROPERTYDAMAGE OR LOSS, OR OTHER HARM OF WHATEVER NATURE, WHETHER FORESEENOR UNFORESEEN, THAT I MAY SUSTAIN OR SUFFER AS A DIRECT ORINDIRECT CONSEQUENCE OF MY PARTICIPATION IN EQUINE ACTIVITIES OR BY MYPRESENCE IN EQUINE ACTIVITIES WITH THE PROVIDERS, WHETHER CAUSED BY THEUNINTENTIONAL NEGLIGENCE OF THE PROVIDERS OR OTHERWISE.

4)**Promise Not to Bring Suit:** I hereby agree and promise that I, my heirs, successors in interest, guardians, legal representatives and assigns will not bring a claim against, sue, demand compensation from or attach the property or assets of the Providers, either on my own behalf, or on behalf of any other person, for any loss or damage arising or resulting directly or indirectly from my participation in Equine Activities with the Providers.

5)**Ohio Equine Activity Statute:** I understand that Title XXIII, Chapter 2305, Section (B)(1) of the Ohio Revised Code provides in part, that, ñé An equine activity sponsor, equine activity participant, equine professional,é or other person is not liable in damages in a tort or other civil action for harm that an equine activity participant allegedly sustains during and equine activity and that results from an inherent risk of an equine activity. é An equine activity participant or the personal representative of an equine activity participant does not have a claim or cause of action upon which a recovery of damages may be based against, and may not recover damages in a tort or other civil action against, an equine activity sponsor, another equine activity participant, and equine professional, é or another person for harm that the equine activity participant allegedly sustained during an equine activity that resulted from an inherent risk of equine activity.ò

6)**Full Understanding:** I hereby warrant that:

a. I HAVE VOLUNTARILY ENTERED INTO THIS AGREEMENT OF MY OWN FREE WILL, WITHOUT DURESS OR PRESSURE FROM ANY PERSON; and

b. I UNDERSTAND AND ACKNOWLEDGE THAT BY SIGNING THISAGREEMENT I AM GIVING UP CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TORECOVER DAMAGES IN CASE OF INJURY, DEATH OR PROPERTY DAMAGE. IUNDERSTAND THAT THIS DOCUMENT IS A PROMISE NOT TO SUE.

7) **Choice of Law, Jurisdiction:** The terms of this agreement shall be governed by and interpreted according to the law of the State of Ohio, the courts of which shall have exclusive jurisdiction over any matter arising hereunder.

8) **Severability:** I agree that this document is intended to be as broad and inclusive as permitted by Ohio law. If any portion of the Agreement is determined to be invalid, illegal or unenforceable, that portion shall be severable, and the validity, legality and enforceability of the balance of the Agreement shall not be affected or impaired in any way and shall continue in full force and effect.

I HAVE READ THIS ENTIRE AGREEMENT (2 pages) CAREFULLY. I FULLY UNDERSTAND ALL OF ITS TERMS AND CONDITIONS. MY SIGNATURE BELOW IS ACKNOWLEDGEMENT THAT I HAVE HAD AN OPPORTUNITY TO CAREFULLY READ THE ENTIRE AGREEMENT AND TO HAVE ANY QUESTIONS ANSWERED TO MY SATISFACTION.

The Participant: _____ Date: _____

Equestrian Therapy Program

Photo Release Form

I_____give permission for the Equestrian Therapy Program to take still and moving photographs and films, including television pictures, of our son/daughter/ward/self _____.

In addition, I consent and authorize the ETP and its advertising agencies, the news media, and any other person or organization interested in the ETP and its work to use and reproduce said photographs, films and pictures, and to circulate and publicize the same by any and all means, including, but not limited to, news-papers, magazines, television, brochures, pamphlets, instructional materials, books, and clinical material.

No inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of the ETP to use said photographs, films and pictures for the primary purpose of promoting and aiding the ETP and its work. The ETP is a nonprofit Ohio corporation.

Date: _____

_____ _____
Signature of Witness Signature of Parent(s)/ Guardian

_____ _____
Signature of Witness Signature of Participant (if over 18)

If you do consent to the above, then this form needs to be signed by the participant, if over age 18, and either by both natural parents, or by the sole parent having legal custody, or by the participantôs legal guardian.

No Photo

I_____do not consent to photos or moving pictures of son/daughter/ward/self.

Date: _____

_____ _____
Signature of Witness Signature of Parent(s)/ Guardian

_____ _____
Signature of Witness Signature of Participant (if over 18)

22532 Bowsher Road · Cridersville, Ohio 45806 · Phone (419) 657-2700 · Fax (419) 657-2887

The Equestrian Therapy Program

Participant Guidelines

1. The participant must be **FOUR** years of age and have a minimum sitting balance and head control of a 6-month-old. Students who have had a Gran Mal seizure within the last year may not be eligible for horseback riding.
2. Our weight limit for riding is determined by assessment and available equine.
3. All participants with Down Syndrome **MUST** have a neurological examination annually by a physician to rule out AAI (Atlantoaxial Instability). The results must be noted/dated on the Physicianôs Referral Form. We are not permitted to ride anyone with symptoms of AAI.
4. **ALL FORMS MUST BE FILLED OUT, SIGNED** and returned to us before the participant may ride. No participant will be permitted to ride without these forms.
5. When riding, the participant must be in a sturdy, close toe shoe and long pants preferred for comfort but not required. **SANDALS ARE NOT PERMITTED** due to the possibility of foot injuries. Approved helmets are required and provided. Please remember to wear hair styles that are conducive to a snug-fitting helmet. Avoid dangling earrings and other jewelry. Please also avoid slip on shoes/crocs/slippers/etc.
6. Please observe all barn rules while at the farm. All family and visitors should stay inside the bleacher/lounge area of the barn unless specifically invited to go to another part of the building.
7. Our volunteers give of their time and talent so that you are able to ride. **PLEASE** let us know **AS SOON AS POSSIBLE** if you will be unable to attend class so that we can schedule our volunteers accordingly. The number to call is:

Office: 419-657-2700
Email:programs@etpfarm.org

If cancellation is less than 24 hours of scheduled lesson, please call. Leave a voicemail if no one answers

During extreme weather, not conducive to riding, we will provide alternative activities. In the event that travel is not advisable we will cancel classes, see WLIO for cancellations or call the office. We will call you at the numbers you have provided on your forms if we have to cancel due to inclement weather or other circumstances.

8. If a participant has **TWO UNEXCUSED, NO CALL NO SHOW ABSENCES** in a session, we reserve the right to **EXCUSE THEM FROM THE PROGRAM**. We have a waiting list of students who would like to ride.
9. If we determine that this type of riding therapy is not suitable for a participant because of safety to the participant, volunteer, instructor, horse, or for any other reason, we reserve the right to deny riding to that participant.
10. Due to full scheduling and more than reasonable fees, which are discounted over 80 percent of our cost, there will be no make up classes or reimbursements, except in unusual circumstances. ñRidershipsò may be made available to those who qualify, please ask for an application.

Thank You for Your Cooperation,

The Equestrian Therapy Program Staff

22532 Bowsher Road · Cridersville, Ohio 45806 · Phone (419) 657-2700 · Fax (419) 657-2887

The Equestrian Therapy Program

Barn Rules

1. Riders must wear a helmet when mounted and working with a horse.
2. No chewing gum while mounted.
3. Everyone is to walk quietly through the barn, without running.
4. Always walk around the head of the horse when possible, not behind.
5. Respect all persons, animals and property.
6. Students (adults and youths) must always stay with an instructor, volunteer, or teacher when going beyond waiting area.
7. Treats can only be fed to the horses with instructor permission and with the help of a volunteer. No feeding from your hand only use **Treat Bowls.**
8. Students must wear sturdy closed-toe shoes. Sandals, slip on shoes, or crocs are NOT permitted.
9. Indoor voices and appropriate language must be used at all times.
10. Pet the horses on the neck or shoulder ï not the face. Approach them in a slow quiet manner.
11. Listen to the instructor and follow directions carefully.
12. Staff, volunteers, and participants will silence their cell phones during equine assisted activities and/or while handling equines. Under no circumstances will staff, volunteers, or participants answer their cell phones during equine assisted activities or while handling equines. There are times when the instructors may need to use their phone for safety reasons or other issues.

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The Equestrian Therapy Program

Physician's Referral Form

Date:_____
Dear Physician:

Your patient,_____, is interested in participating or continuing therapeutic riding. In order to safely provide this service, The Equestrian Therapy Program requests that you complete/update the attached Physicianôs Referral Form and Medical History. Please note that the following conditions may suggest precautions or contraindications to therapeutic riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic	**Yes**	**Degree**	**Neurological**	**Yes**	**Degree**
Spinal Fusion			Hydrocephalus/shunt		
Spinal Instabilities/Abnormalities			Spina Bifida		
Atlantoaxial Instabilities			Tethered Cord		
Scoliosis			Chiari II Malformation		
Kyphosis			Hydromyelia		
Lordosis			Paralysis due to Spinal Cord Injury		
Hip Subluxation & Dislocation			Seizure Disorders		
Osteoporosis			AAI or Focal Neurological Disorder		
Pathologic Fractures					
Coxas Arthrosis			**Medical/Surgical**		
Heterotopic Ossification			Allergies		
Osteogenesis Imperfecta			Cancer		
Cranial Deficits			Poor Endurance		
Spinal Orthoses			Recent Surgery		
Internal Spinal Stabilization Devices			Serious Heart Condition		
			Stroke (Cerebrovascular Accident)		
Secondary Concerns			Peripheral Vascular Disease		
Behavior Problems			Varicose Veins		
Acute exacerbation of chronic disorder			Hemophilia		
Indwelling catheter			Hypertension		
			Diabetes		

Patient's with Down Syndrome must have additional information provided (see back of page 2 following Ambulation Information).

Thank you very much for your assistance. If you have any questions or concerns regarding this patientôs participation in therapeutic riding, please feel free to contact The Equestrian Therapy Program at the address/telephone number indicated below.

Sincerely,
The Equestrian Therapy Program Staff

Physician Signature: _____

The Equestrian Therapy Program

Physician's Referral Form

Name:_____ Name of Parent/Guardian: _____

Address:_____ City:_____ State:_____ Zip: _____

Diagnosis:_____ On Set: _____

Date of Birth:_____ Height:_____ Weight:_____ Tetanus Shot: Yes NO Date:_____

Seizure Type:_____ Controlled:_____ Date of last Seizure: _____

Medications: _____

Health History

Please indicate if the patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Hearing			
Vision			
Communication			
Balance			
Coordination			
Spasticity/Rigidity			
Muscular			
Neurological			
Orthopedic (Bone/Joint)			
Heart/Circulation			
Sensation			
Pain			
Incontinence			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
Other			

Given the patient's diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that The Equestrian Therapy Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The Equestrian Therapy Program for ongoing evaluation to determine eligibility for participation.

Physician's Name (please print): _____

Physician's Signature:_____ Date:_____

Date: _____

Address:_____ City:_____ State:_____ Zip: _____

Phone:_____ Fax:_____ Email: _____

****Down Syndrome patients need additional information completed on reverse of this page.**

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The Equestrian Therapy Program

Physician's Referral Form

Patient's name: _____

Mobility Information:

Independent Ambulation	Yes	No
Crutches	Yes	No
Braces	Yes	No
Wheelchair	Yes	No

****Mandatory for persons with Down Syndrome:**
*Persons with symptoms of AAI are not appropriate for therapeutic riding activities. It is a requirement for therapeutic riding that all individuals with Downs Syndrome be **examined yearly** for AAI.*

To be completed by Physician:

Does this patient present symptoms consistent with Antlantoaxial Instability or Focal Neurological Disorder?

YES NO

This patient does not show signs or symptoms of Atlantoaxial Instability or Focal Neurological Disorder.

Date of examination: _____

Physician Signature: _____

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