The Equestrian Therapy Program

Student's Information & Health History

For office use only
Referral:

Payment Code:

Student's Name: _____

Parents/Guardian: _____

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

Phone: _____ Cell: _____ E-mail: _____

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

Caregiver: _____ Phone: _____

Please contact named individual in the event of a cancellation if different from student's phone number.

Name: _____ Phone: _____

Students Disability: _____ DOB: _____ Weight: _____ Height: _____

Gender: M F Date of Onset: _____ Secondary Diagnosis: _____

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			
Other			

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

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

_____

Please Sign that the above information is accurate to the best of your knowledge.

Signature: _____

The Equestrian Therapy Program

Emergency Medical & Consent Form

Students Name: _____

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

Physician's 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: _____
(Student 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 participant's 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: _____
(Student 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 participant's legal guardian.

3/28/11

WAIVER AND RELEASE OF LIABILITY

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY,
AND INDICATE YOUR UNDERSTANDING, AGREEMENT, AND
ASSENT BY SIGNING AS INDICATED BELOW.

I / We, the undersigned, understand that equine activities are inherently dangerous and that this danger or condition is an integral part of an equine activity. The inherent risk presented by equine activities includes, but is not limited to, any of the following: (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 equine's reaction to sounds, sudden movement, unfamiliar objects, persons, or other animals; (c) Hazards, including, but not limited to, surface or subsurface conditions; (d) A collision with another equine, another animal, a person, or an object; (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 riding instruction requires that the instructor give direction in the form of "commands", and while due deference should be given to such commands, I realize that all my activities are voluntary, and I should use my own judgment in choosing whether to comply with any suggested act. The instructor is entitled to my attentiveness and good faith efforts to cooperate, but does not expect or require absolute obedience, especially if such compliance might cause injury or harm to myself, my horse, or any person, animal or property.

I understand that horseback riding and training is a rigorous activity, requiring both physical fitness and mental alertness at all times. I certify that I am in good health and free from injury, illness, or other defect, which might impair my ability to engage in this activity.

I expressly and voluntarily assume all risks attendant to horseback riding and related activities, including but not limited to those discussed in the above paragraphs. I do hereby fully and forever release, discharge, and hold harmless Fassett Farm and the Equestrian Therapy Program, as well as other students, volunteers and the assigns of the same, from any and all claims which I or my assigns may assert as a result of physical injury to me, or loss of damage to property, incurred while a participant is using, handling, or riding a horse while at Fassett Farm as a visitor, whether a program horse or my own horse.

My signature on this form constitutes my understanding and agreement to all the statements above and gives Fassett Farm and the Equestrian Therapy Program and their assigns my total and unconditional release from any and all claims of liability or damage. This Waiver and Release shall remain valid until revoked in writing.

DATE_____

_____ _____
SIGNATURE OF WITNESS SIGNATURE OF PARTICIPANT

_____ _____
SIGNATURE OF WITNESS SIGNATURE OF PARENT/GUARDIAN

_____ _____
SIGNATURE OF WITNESS SIGNATURE OF SECOND PARENT

PARTICIPANTS UNDER AGE EIGHTEEN (18) MUST HAVE THIS FORM SIGNED EITHER BY BOTH NATURAL PARENTS, OR BY THE SOLE PARENT HAVING LEGAL CUSTODY, OR BY THE PARTICIPANT'S LEGAL GUARDIAN.

22532 Bowsher Road, Cridersville, Ohio 45806 – PH: 419-657-2700 – FAX: 419-657-2887

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 participant's 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)

3/28/11

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The Equestrian Therapy Program

Student Goal Checklist

Student Name: _____ Age: _____

Diagnosis: _____

To assist our instructor in formulating both mounted and classroom lesson plans, please mark each item below if it is an individual goal for this student. These skills can be directly applied to experiences at the Equestrian Therapy Program (i.e. feeding horses, working with others, games and activities, etc.).

For each category, **please prioritize these items**, with #1 being the most important area.

Priority	Education Goals	Priority	**Physical Goals**	**Priority**	**Social/Recreational Goals**
	Color Recognition		Balance		Attention Span (inc/decr)
	Math Skills: Numbers, +, -, x, fractions, etc.		Coordination		Communication Skills
	Reading Skills: Letters, words, Sentences		Eye/Hand Coordination		Confidence/Self-esteem
	Sequencing		Fine Motor Skills		Cooperation
	Shape Recognition		Gross Motor Skills		Enjoyment
	Spatial Awareness		Head Control		Increase Acceptance Social Behavior
	Verbalization		Increased R.O.M.		Responsibility
	Vocabulary Expansion		Muscle Strength		Self-sufficiency
			Muscle Tone		Socialization
	Other		Posture		Sportsmanship
			Tactile Defensiveness		
			Trunk Control		Other:
			Other:		

How would you (as student, parent, teacher, therapist, recreational advisor) like to be involved in the program?

_____

If this client has any special issues (behavior, sensory, social, etc.), how do you prefer to handle typical situations? _____

Completed by: _____ Date: _____

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The Equestrian Therapy Program

Physical Therapy Assessment

Name:	Age:	Date:
Disability:		
School/Occupation:		
Evaluation Summary:		
Suggested Mounting Procedure:		
Suggested Exercises:		
Precautions and/or Contraindications:		

Signed: _____, RPT Date: _____

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The Equestrian Therapy Program

Student Information

Dear Parent/Guardian,
Please take the time to fill out this page. The information that you have as this students parent is valuable to us as we form goals and activities for your child.

Name: _____ Student Name: _____ Date: _____

What is your child's special (favorite) topic or three top interests? (Toy, game, thing he/she loves to talk about). Please list them in order of preference.

Please list any triggers of inappropriate behavior. (Types of music, sounds, textures, colors)

Please list favorite colors, sounds, tastes, and textures.

Are there environments that your child struggles with and/or environments that they do especially well in?

Does your child have an IEP (Individualized Education Plan)? Are there things you would like the ETP to focus on for your child?

If your child has SID, please specify the type?

Is your child currently in a behavior modification program?
If yes, please explain the behavior(s) and how it is addressed.

Please tell us any other information that you feel may be useful in engaging and working with your child.

Thank you for taking the time to fill out this form. Please feel free to communicate suggestions, concerns or changes in the above information with your child's Riding Instructor.

Sincerely,

The Equestrian Therapy Program Staff

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, 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 long trousers that fit neatly and sturdy closed-toed shoes.
9. Indoor voices and appropriate language must be used at all times.
10. Pet the horses on the neck or shoulder – not the face. Approach them in a slow quite 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.

3/13/14

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The Equestrian Therapy Program

Student Guidelines

1. The student 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 Physician's 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 student may ride. No student will be permitted to ride without these forms.
5. When riding, the student must be in long pants and a sturdy shoe, preferably with heels. **SHORTS AND SANDALS ARE NOT PERMITTED** due to the possibility of pressure sores, pinched legs or foot injuries. Approved hard hats are required and provided. Please remember to wear hair styles that are conducive to a snug-fitting hard hat. Avoid dangling earrings and other jewelry.
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 numbers to call are:

   Office: 419-657-2700 Fax: 419-657-2887
   Website: www.etpfarm.org Sarah: 419-302-2039
   Email: etpfarm@etpfarm.org

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.

8. If a student has **TWO UNEXCUSED ABSENCES** in a session, they will be **EXCUSED 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 student because of safety to the student, volunteer, instructor, horse, or for any other reason, we reserve the right to deny riding to that student.
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. "Riderships" may be made available to those who qualify, please ask for an application.

Thank You for Your Cooperation,

The Equestrian Therapy Program Staff

3/12/2014

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 Physicians 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 patient's 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: _____

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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: _____

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

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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