The Buffalo Therapeutic Riding Center

Participant Application

Date: _____

GENERAL INFORMATION

Participant Name:_____

DOB:_____ AGE:_____ Gender: Male / Female

Address:_____

_____

Primary Phone Number:_____

School:_____

Home Address:_____

City _____ State: _____ Zip: _____

Parent(s) or Legal Guardian(s):

Name: _____ Phone:_____ E-mail:_____

Name: _____ Phone:_____ E-mail:_____

Name: _____ Phone:_____ E-mail:_____

Address (if different than above):_____

_____

Referral Source:_____

Phone:_____

GOALS

_____

_____

Does the participant have any riding experience? *(please explain)*

_____

_____

Are there any special considerations to be aware of? *(please explain)*

_____

_____

The Buffalo Therapeutic Riding Center

Authorization for Emergency Medical Treatment

Name:_____ DOB: _____Phone:_____

Address:_____

Physician's Name:_____ Preferred Medical Facility:_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

Other Allergies: _____

Current Medications:_____ _____

Emergency Contacts:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

CONSENT PLAN

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 The Buffalo Therapeutic Riding Center to:

1.Secure and retain medical treatment and transportation if needed.

2.Release client information on request to the authorized individual or agency involved in the medical treatment.

This authorization includes x-rays, 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_____

(Parent or Legal Guardian)

NON-CONSENT PLAN

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 on the property of the agency. In the event emergency medical treatment/aid is required, I wish the following procedures to take place:

_____

_____

Date:_____ Non-Consent Signature_____

(Parent or Legal Guardian)

The Buffalo Therapeutic Riding Center

Participant's Consent for Release of Information

I hereby authorize: The Buffalo Therapeutic Riding Center to release information from the records of: (participant's name)_____ DOB: _____. The information is to be released to: The Buffalo Therapeutic Riding Center for the purpose of developing an equine activity program for the above named participant and to assist the center in any media/ fundraising endeavors. The information to be released is indicated below.

- □ Medical History
- □ Physical Therapy evaluation, assessment and program plan
- □ Mental Health diagnosis and treatment plan
- □ Individual Habilitation Plan (I.H.P.)
- □ Psychosocial evaluation & assessment
- □ Cognitive-Behavioral Management Plan
- □ Other _____

Signature:_____ Date:_____

Print Name:_____

Relation to Participant: _____

PHOTO/AUDI-VISUAL RELEASE

- □ I DO
- □ I DO NOT

Consent to and authorize the use and reproduction by the BUFFALO THERAPEUTIC RIDING CENTER and the staff of any and all photographs and any other audio/visual materials taken of _____ for promotional material, educational activities, exhibition or for any other use for the benefit of the program, the facility or the staff.

Signature:_____ Date:_____

(Parent or Guardian)

The Buffalo Therapeutic Riding Center

RELEASE

In consideration of taking lessons, riding horses, and using the facilities at The Buffalo Therapeutic Riding Center / the Buffalo Equestrian Center, Inc., I, individually, and/or as parent /guardian of the below named minor(s), do hereby consent to assume all risks in connection with such lessons, horseback riding, and use of facilities, and agree to waive, release, and discharge The Buffalo Therapeutic Riding Center / The Buffalo Equestrian Center, Inc., its officers, employees, and members, from any and all liability, claims, and actions whatsoever for damages or injury (including fatality) to me and/or said minor(s) by reason of such lessons, horseback riding or use of facilities or otherwise. I further agree to indemnify and hold harmless The Buffalo Therapeutic Riding Center / the Buffalo Equestrian Center, Inc. against any loss or damage which it may sustain in consequence of my use or said minor's use of the horses and facilities and no agreement, either verbal or written, will in a any manner affect this release, which shall be binding upon the heirs, executors and administrators of myself and/or of the said minor(s) listed hereon.

_____ _____

Notarized Individually and/or parent/guardian

of the following minor

_____ _____

Date

The Buffalo Therapeutic Riding Center

Participant's Medical History & Physicians Statement

(Must be completed by a Health Care Professional)

Participant: _____ Age: _____

DOB:_____ Sex:_____ Height:_____ Weight:_____ BMI:_____

*For safety reasons riders must be between the ages of 6 to 18, and they cannot exceed 5'7" and 150 pounds.

Diagnosis:_____ Date of Onset:_____

Medications:_____

_____

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

Braces/Assistive Devises:_____

CONTRAINDICATION

(Participants presenting with the following issues should NOT ride horses according to PATH International)

Atlanto Axial Instability: AtlantoDens Interval X-rays Date:_____ Result: + –

Shunt Present: **Y N** Type:_____ Date of last revision:_____

Seizures: **Y N** Type:_____ Controlled: **Y N** Date of last seizure:_____

Indwelling Catheter Present: **Y N**

THERAPEUTIC AND SAFETY ISSUES

Orthopedic

□ Coxarthrosis
□ Cranial Defects
□ Osteoporosis
□ Pathological Fractures
□ Joint subluxation/dislocation
□ Heterotopic/Myositis Ossification
□ Spinal Fusion/Fixation
□ Spinal Instability/Abnormalities

Neurologic

□ Hydrocephalus/Shunt
□ Siezures
□ Spina Bifida
□ Chiari II Malformation/Tethered Cord/Hydromyelia

Medical/Psychological

□ Allergies
□ Blood Pressure Control
□ Fire Setting
□ Hemophilia
□ Medical Instability
□ Migraines
□ Exacerbation of Medical Conditions
□ Physical/Sexual/Emotional Abuse
□ Animal Abuse
□ Dangerous to Self or Others
□ PVD
□ Respiratory Compromise
□ Recent Surgeries
□ Substance Abuse
□ Cardiac Conditions
□ Thought Control Disorders
□ Weight Control Disorders

Other

□ Age (under 6 years)
□ Poor Endurance
□ Skin Breakdown
□ Medications (ex: Photosensitivity)
□ Indwelling Catheters/Medical Equipment

The Buffalo Therapeutic Riding Center

Physician's Statement Page 2

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

Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neuroligic			
Muscular			
Balance			
Orthopedic			
Allergies			
Leaning Disability			
Emotional/Psuchological			
Pain			
Other			

Given the preceding diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Buffalo Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other_____

Address:_____

Phone:_____ E-mail:_____

License/UPIN Number:_____

Signature:_____ Date:_____