A HORSE CONNECTION

REGISTRATION PACKET

Date: ___________________________

Client: ____ Date of Birth: ________________ Age: _______

Address: ____

Parents or Guardian: ____

Address: ____

Daytime Phone (HOME/WORK): ________________ Evening Phone (HOME/WORK): __________________

Mobile or Pager Number: _____________________________

Email Address: _______________________________________

School or Facility presently attending: ____

In case of emergency contact: ___________________________________ Phone: ____________________

Or Contact: _______________________________________ Phone: _____________________

Have you or your child ever been around or on a horse or pony? Please describe when, where, response.

Please provide any scheduling information you have that will help us meet your needs, ie: Preferred Days/Times/Hours of school/Hours of work:

Please use the space to provide any additional information or experience you would like to provide that will help the equine assisted therapy team best serve you/your child's needs:

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If services are for your child, does your child have siblings? If so, have they ever been around or on a horse/pony? Please describe.

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

Describe participant's abilities/difficulties in the following areas (include assistance required or equipment needed).

PHYSICAL FUNCTION (ie Mobility skills such as transfers, walking, wheelchair use, driving):

PSYCHOSOCIAL FUNCTION (ie Work/school, leisure interests, support systems, family relationships, companion animals, fears/concerns/aspirations, etc):

COMMUNICATION FUNCTION (ie verbal, non-verbal, gestural, picture/symbols - Methods used for current communication, etc.):

GOALS (ie Why did you apply for participation? What would you like to accomplish?):

Thank you for taking the time to fill out this information that will be helpful in best serving your needs!

PO Box 473 • Saugerties, NY 12477 • Phone: 845-417-4646 • Email: info@ahorseconnection.com • www.ahorseconnection.com

Last Revised Date: May 22, 2006

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HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Yes or No	Comments
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional		
Behavioral		
Pain		
Bone/Joint		
Muscular		
Thinking/cognition		
Allergies		

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize:____(Facility/Person)

To release information from the records of:____________________________(Participant Name) whose Date of Birth is:________________________________.

The information is to be released to: Nancy King, OTR/L for the purpose of developing an Occupational Therapy Program for the above named participant. The information to be released is marked below:

____ Medical History

____ Occupational Therapy evaluation, assessment and program plan

____ Speech Therapy evaluation, assessment and program plan

____ Physical Therapy evaluation, assessment and program plan

____ Classroom Individual Education Plan (I.E.P.)

____ Psychosocial Evaluation, assessment and program plan

____ Cognitive-Behavioral Management Plan

Other: ____

A HORSE CONNECTION agrees to maintain all information received in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Date: ___________ **Signature:** ______________________________ (Participant, Parent or Legal Guardian)

Please send materials to:
Nancy King
A HORSE CONNECTION
PO Box 473
Saugerties, NY 12477 • (845) 417-4646

A HORSE CONNECTION

LIABILITY RELEASE FORM

_____________________________ (Client's Name) would like to participate in the Equine Assisted Therapy Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against A HORSE CONNECTION, Nancy King, OTR/L/King Management, Inc./The Southlands Foundation, each organization's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and or losses I/my son/my daughter/my ward may sustain while participating in the Equine Assisted Therapy Program.

Signature: _____________________________________ (Client, Parent or Guardian)

Date: ____________________________

A HORSE CONNECTION

CONSENT TO PHOTOGRAPH, TAKE MOTION PICTURES, VIDEO TAPE, SOUND RECORD AND/OR TELEVISION

Parent/Guardian/Client

I hearby give A HORSE CONNECTION and Nancy King the right to photograph, televise, film, video tape and/or sound record the acts, appearances and utterances of ___________________________ (Client Name) and to use any descriptive words or names, including the name of _______________________ (Client Name) in connection therewith and without limit as to time, to produce and reproduce the same or any part thereof by any method and to use said photographs, films, video tapes and/or sound recordings for any purpose which A HORSE CONNECTION and Nancy King deems proper in the interest of newspapers, television media, brochures, pamphlets, instructional material, books and clinical material, medical education, knowledge and/or research. All such photographs, films and/or sound recordings shall be the exclusive property of A HORSE CONNECTION and Nancy King and I hereby relinquish all right, title and interest therein.

With respect to the foregoing, no inducements or promises have been made to me to secure my signature to this release other than the intention of A HORSE CONNECTION and Nancy King to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding A HORSE CONNECTION and Nancy King and it's work.

Signature: _____________________________________ (Client, Parent or Guardian)

Date: ____________________________

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: ____________________________________ Date of Birth: ____________ Age: ______

Address: ____

Physician's Name: _______________________________________ Medical Facility: _____________________

Health Insurance Co.: ____________________________________ Policy No.: __________________________

Allergies to medications? ____

Current medications: ____

In the event of an emergency, contact:

Name: ______________________________________ Relation: ______________ Phone: __________________

Name: ______________________________________ Relation: ______________ Phone: __________________

Name: ______________________________________ Relation: ______________ Phone: __________________

In the event ermergency 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, and the above cannot be reach, I authorize Nancy King, OTR/L to:

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

2) Release participants records upon request to the authorized individual or agency involved in the medical emergency treatment.

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 above is unable to be reached.

Date: _______________

Consent Signature : ____ (Client, Parent or Legal Guardian)

MUST BE SIGNED IN THE PRESENCE OF OPERATING CENTER STAFF

A HORSE CONNECTION

Date: ____________________

Dear Physician:

Your patient, (participant's name)____ is

____ Interested in participating in hippotherapy

____ Interested in continuing to participating in hippotherapy

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to hippotherapy. 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 Fusion/Fixation
Spinal Instability/Abnormalities

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

OTHER
Age - under 4 year
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
Fire Setting
Heart conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in hippotherapy, please feel free to contact the operating center at the address and phone number indicated above.

Sincerely,

Nancy King, MS, OTR/L

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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: ______________________________ Date of Birth: ____________ Height: _______ Weight: _______

Address: ____

Diagnosis: ____

____

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ______________________ Controlled?: Yes No Date of last seizure: ______________

Shunt present?: Yes No Date of last revision(s): ____________ Date of last Tetanus Shot: ______________

Special Precuations/Needs: ____

____

Mobility: Independent Amulation? Yes No Assisted Ambulation? Yes No Wheelchair? Yes No

Braces/Assistive Devices: ____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
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 therapeutic riding 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, Speech Language Pathologist, Psycholigist, etc.) in the implementation of an effective equestrian program.

Name/Title: ______________________________ MD DO NP PA Other: ______________

Signature: ______________________________ Date: ______________

Address: ______________________ City ______________ State ______ Zip ____________

Phone: (____) ______________________ License/UPIN Number: ______________________