

Partners Therapeutic Horsemanship

Name _____ S V

AGREEMENT FORM FOR FULL ASSUMPTION OF RISK AND RELEASE OF ALL LIABILITY

I, the undersigned, am of legal adult age and of sound mind do for myself, or on behalf of my child or legal ward, or other minor listed below, for whom I hereby attest to accepting full responsibility for (hereinafter all inclusively "the rider"), hereby voluntarily request to participate in the horseback riding activities directed by Partners Therapeutic Horsemanship, Inc.

I, and/or the rider will ride and work with either a horse provided by Partners, my own horse, or a horse provided by a third party. I understand that I and/or the rider is responsible for all bodily injury and or property damage which I, and or the rider, and or the rider's horse should cause or receive either on the premises of Donald and Margaret Bright, Lone Oak Ranch and the Bright Family Trust dated Jan. 16, 1989 or any other property including any trails while accompanying other horses or riding alone or receiving instruction. Furthermore, I accept all responsibility and liability for any incident involving the rider and or the rider's horse with any other rider, horse, individual or property.

I understand that horseback riding is a dangerous activity and that there are dangers from even being near a horse and that any horse, even the most gentle, can be provoked or frightened and as a result act or react in a dangerous or unpredictable manner. We agree not to touch, pet or feed any horses or enter the horse's pens with out the horses owners' permission or to provoke or otherwise influence our horse or the horse of another rider at any time as this can be very dangerous.

I understand that horses are animals and as such are unpredictable by nature; that when frightened, angry, under stress, or for no reason at all, a horse's natural instincts are to move, shake, bolt, jump forward or sideways, to run away from danger, to kick, to buck, to rear up in front, or to bite. Any horse may bite or kick me or anther rider or horse. I understand that horses are extremely heavy and powerful and that if I fall to the ground the fall distance will be generally from 4 to 6 feet or if a horse lays down on me that the weight may be between 500 to 2,000 pounds. I understand that any or all of the horse activities directed by Partners Therapeutic Horsemanship, Inc., or their representatives, may cause myself and or the rider serious permanent injury or death and I and or the rider agree to participate in this activity willingly and voluntarily.

I hereby agree not to bring any suit against Partners Therapeutic Horsemanship, Inc., or their representatives, their successors, assigns, agents, affiliates, owners, employees, officers, members or Board of Directors, advertisers, sponsors or supporters and volunteers for any reason at any time now or in the future for any injury, damage, or incident which may occur as a result of my participation in any activity offered and provided by or affiliated with Partners Therapeutic Horsemanship, Inc., or their representative. I and the rider hereby for ourselves, heirs, administrators, assigns and representatives completely release, indemnify, hold harmless and discharge the owners, operator, sponsors, agents, associates and employees of Partners Therapeutic Horsemanship, Inc., or their representatives, and their respective agents, representatives, associates and all other participants of and from Partners Therapeutic Horsemanship, Inc. equestrian activities. I furthermore agree to reimburse Partners Therapeutic Horsemanship, Inc. upon demand for any and all expenses incurred as a result of any action, legal or otherwise, that I, my heirs, administrators, assigns, representatives or agents or those of the rider may initiate against Partners Therapeutic Horsemanship, Inc., and/or their agents, representatives, associates or other participants now or in the future.

I understand Donald and Margaret Bright, Lone Oak Ranch and the Bright Family Trust dated Jan. 16,1989 are a completely separate entity from Partners Therapeutic Horsemanship, Inc., and hereby agree not to bring any suit against Donald and Margaret Bright, Lone Oak Ranch and the Bright Family Trust dated Jan. 16, 1989, their clients or client's horses, their successors, assigns, agents, affiliates, employees, officers, members or Board of Directors, advertisers, sponsors or supporters and volunteers for any reason at any time now or in the future for any injury, damage, or incident which may occur as a result of my participation in any activity offered and provided by or affiliated with Partners Therapeutic Horsemanship, Inc. I and the rider hereby for ourselves, heirs, administrators, assigns and representatives completely release, indemnify, hold harmless and discharge the owners, operator, sponsors, agents, associates and employees of Partners Therapeutic Horsemanship, Inc.,

their respective agents, representatives, associates and all other participants of and from Partners Therapeutic Horsemanship, Inc., and Donald and Margaret Bright, Lone Oak Ranch, and the Bright Family Trust dated Jan. 16, 1989. I furthermore agree to reimburse Partners Therapeutic Horsemanship, Inc., Donald and Margaret Bright, Lone Oak Ranch and the Bright Family Trust dated Jan. 16, 1989 upon demand for any and all expenses incurred as a result of any action, legal or otherwise, that I, my heirs, administrators, assigns, representatives or agents or those of the rider may initiate against Partners Therapeutic Horsemanship, Inc., and Donald and Margaret Bright, Lone Oak Ranch and the Bright Family Trust dated Jan. 16, 1989 and or their agents, representatives, associates or other participants now or in the future.

In the event that any of the terms or conditions of this document is held to be illegal, unenforceable or invalid by any court of competent jurisdiction, the legality, validity and enforceability of the remaining terms or conditions shall not be affected thereby.

I acknowledge that I have read, understand, agree and accept all provisions, conditions, warnings, and dangers as stated. I understand this agreement and assumption of risk and liability release document and I assume any and all risks inherent in all horse related activities whether stated herein or not and that I completely release, indemnify and hold harmless Partners Therapeutic Horsemanship, Inc., and any other affiliate entity from any and all liability or responsibility for any incident, accident, damage injury, illness or loss to the rider, rider's horse, the undersigned or to any family member, spectator or guest accompanying the undersigned or in the care of the undersigned.

I further agree and hereby state under penalty of law that all information provided on this document by the undersigned is true and correct. I further understand and agree that all monies, if any, paid by me, the undersigned or the rider to Partners Therapeutic Horsemanship, Inc., are not refundable in whole or in part for any reason whatsoever. I agree to pay Partners Therapeutic Horsemanship, Inc., in full, at their current rates, prior to riding or beginning work with a horse, for the opportunity to learn horse care and management and riding skills. I agree not to stop or dispute payment for any reason.

Print Responsible Adult's Name: _____

Responsible Adult's Signature:

_____ Date _____

Student/Rider's Name: _____ Age _____

Phone numbers: Home _____

Work _____ Cell _____

Email: _____

Address: _____

Please list any specific concerns (health or otherwise), conditions, learning disabilities, etc.



Participant's Application & Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ E-mail: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

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 and 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: _____

PHOTO RELEASE

- I DO
- DO NOT

consent to and authorize the use and reproduction by _____
(center)

of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian
Signed in the presence of center staff

Authorization for Emergency Medical Treatment

Participant Staff Volunteer

Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy # _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency contact:

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 _____ to:

(Center's Name)

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

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(s) above is unable to be reached

Date: _____ Consent Signature: _____

Client, Parent or Legal Guardian

Signed in presence of center staff

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 being on the property of the agency.

- 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: _____

Client, Parent or Legal Guardian

Signed in presence of center staff

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, our 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

Coxarthrosis

Cranial Defects

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 Coed/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 Settings

Hemophilia

Medical Instability

Migraines

PVD

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 equine assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

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: _____

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + —

Neurologic Symptoms of Atlanto Axial Instability: _____

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 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 NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

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