PARTICIPANT APPLICATION AND HEALTH HISTORY

To be completed by the participant or parent/legal guardian/caregiver

Participant: ____

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

Address: ____

Home Phone: ____________________ E-mail: ____________________________________

Work Phone: _____________________ Cell Phone: __________________________________

Alternate Phone (specify): ____

Employer/School: ____

Occupation: ____

Parent/Legal Guardian/Caregiver: ____

Address (if different from above): ____

Phone (if different from above): ____

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 (as they relate to participation in therapeutic riding)

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____

____

____

PHOTO RELEASE

- ☐ I DO
- ☐ I DO NOT

Consent to and authorize the use and reproduction 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: ___________________

RELEASE AND HOLD HARMLESS AGREEMENT
FOR ADULT RIDERS

I, _________________________, of legal age and desiring to ride and/or take horseback riding lessons at Great and Small, do hereby release and hold harmless Great and Small, its officers, directors, volunteers, employees and independent contractors, Montgomery County, Mr. Dennis M. Moore, Ms. Devereaux Raskauskas, Ms. Francie Dougherty, Ms. Jennifer Williams, the Great Falls Vaulting Team, the Maryland National Capital Park and Planning Commission, and any and all owners of horses utilized by Great and Small for its riding program, (together, the "Releasees"), from any and all liability that may arise from injury to myself or my property while riding at Great and Small at the Rickman Farm Horse Park. I release the Releasees on behalf of myself, my estate, my heirs and assigns, and anyone claiming on my behalf, from any and all liability that may arise as a result of my involvement with the Great and Small program or while riding at the Rickman Farm Horse Park. I have inspected the premises and find it suitable for riding. I acknowledge that despite the efforts of Great and Small and the other Releasees to make this activity as safe as possible, horses are powerful flight animals that may behave unpredictably, and stables and stable areas contain certain hazards, and I willingly and knowingly assume all risks associated with these facts. Moreover, I acknowledge and accept that some of the children served by Great and Small may have behavioral problems that may result in injury to me or my property, and I knowingly assume those risks as well. In signing this Agreement, I am indicating my belief that the benefits of horseback riding and other activities at the Rickman Farm Horse Park outweigh the risks that may be associated with these activities, and I willingly assume those risks.

READ CAREFULLY BEFORE SIGNING. THIS IS A RELEASE OF YOUR RIGHTS.

Signed: ____ Date: _______________ _____

Print name, address and phone number:

____

____

Email Address: ____

Emergency contact name and number: ____

____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

□ Participant □ Volunteer □ Staff

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:_________________________

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 Great and Small to:

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.

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(s) above is unable to be reached.

Date:________________ Consent Signature:____

Client, 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 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:_______________ Consent Signature:____

Client, Parent or Legal Guardian

Date: ________________

Dear Health Care Provider:

Your patient, ____, 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
Coxa Arthrosis
Cranial Deficits
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 Cord/Hydromyelia

Other:
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical:
Allergies
Cardiac Condition
Blood Pressure Control
Exacerbations of medical conditions (i.e. RA, MS)
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Weight Control Disorders

Psychological:
Animal Abuse
Physical/Sexual/Emotional Abuse
Dangerous to self or others
Fire Settings
Substance Abuse
Thought Control Disorders

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 Atlantoaxial 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/Balance			
Muscular			
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. 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: ____________________________

Participants with Down Syndrome

Client Name: ____ Date of Birth: ______________

AtlantoDens Interval X-rays, date: ________________________________ _ Result: positive negative

Neurological Symptoms of Atlantoaxial Instability: ____

A physical examination of ____ on ___________________

did not reveal atlantoaxial instability or focal neurologic disorder.

_________________________________ _________________

Physician Signature Date

____

Physician Name (Printed)