Therapeutic Riding Of Tryon
The Therapeutic Riding Program at FENCE

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PARTICIPANT'S APPLICATION AND HEALTH HISTORY

To be completed by participant or parent/legal guardian

GENERAL INFORMATION

Participant Name: _____

Birth Date: _____ Age: _____ Height: _____ Weight: _____ Gender: M ____ F____

Address: _____

(Street) (City) (State) (Zip)

Home Phone: _____ Alt. Phone: _____

E-Mail: _____

School or Employer Name: _____

Address: _____

(Street) (City) (State) (Zip)

Name of Parent/Legal Guardian: _____

Address (if different from above): _____

Phone (if different from above): _____

How did you hear about us? _____

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Comunication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking Cognition			
Allergies			

MEDICATIONS *(include prescription, over-the-counter, name, dosage and frequency)*

_____

_____

_____

_____

Please describe abilities or difficulties in the following areas, including assistance or special equipment required:

PHYSICAL FUNCTION *(for example, mobility skills such as walking, driving, riding in a car or bus)*_____

_____

_____

PSYCHO/SOCIAL FUNCTION *(for example, work or school environment, hobbies, relationships within and outside the family, fears or areas of concern)*_____

_____

_____

GOALS: What would you like to accomplish through participation at TROT? _____

_____

_____

LIABILITY RELEASE

I understand that involvement in "equine activity," as defined by applicable laws, involves inherent risks associated with the dangers and conditions which are an integral part of equine activities. These risks include, but are not limited to, the propensity of equines to behave in ways which may result in injury, harm, or even death to humans or other animals around or near them; the unpredictability of equine reaction to sounds, sudden movements, smells, and unfamiliar objects, persons or other animals; hazards related to surface or subsurface conditions; collisions with other equines or objects; and the potential of a participant to act in a negligent or unskilled manner which may contribute to injury to the participant or others, including the failure or inability to maintain control over the animal. By participating in this activity, I agree to assume responsibility for these risks and I release and agree to hold harmless Therapeutic Riding of Tryon, the Foothills Equestrian Nature Center (FENCE), their officers, agents, employees and all volunteers assisting in the conduct of this activity, from all liability for negligence resulting in accidents, damage, injury or illness to myself and my property.

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

PHOTO RELEASE

I ____do

____do not

consent to and authorize the use and reproduction by Therapeutic Riding of Tryon and FENCE 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 Therapeutic Riding of Tryon and FENCE.

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

To be completed by participant or parent/legal guardian

I hereby authorize_____

(name of health care provider or facility)

to release information from the records of _____ Date of Birth: _____

(participant's name)

The information is to be released to Therapeutic Riding of Tryon for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

_____ Medical History

_____ Physical Therapy evaluation, assessment and program plan

_____ Occupational Therapy evaluation, assessment and program plan

_____ Speech Therapy evaluation, assessment and program plan

_____ Mental Health diagnosis and treatment plan

_____ Individual Habilitation Plan (I.H.P.)

_____ Classroom Individual Education (I.E.P.)

_____ Psychosocial evaluation, assessment and program plan

_____ Cognitive-Behavioral Management Plan

_____ Other: _____

I understand that this release is for three years and may be revoked and invalidated by my written request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____ Self _____ Parent _____ Legal Guardian _____ Other (_____)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

To be completed by participant or parent/legal guardian

Participant's Name: _____

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:_____

_____

Choose either the Consent Plan OR the Non-Consent Plan for emergency medical treatment.

Consent Plan

In the event that 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 Therapeutic Riding of Tryon and the Foothills Equestrian Nature Center 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.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will be invoked only if the person(s) above is/are unable to be reached.

Consent Signature: _____ Date: _____

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 procedures to take place:

_____

_____

_____

Non-consent Signature: _____ Date: _____

Client, Parent or Legal Guardian