Rider Registration Packet

Please fill out completely and return to:

The Therapeutic Equestrian Center

537 Northampton Street
Holyoke, MA 01040
413-532-1462
info@EquestrianTherapy.org
www.EquestrianTherapy.org

Therapeutic Equestrian Center
537 Northampton Street, Holyoke, MA 01040
413-532-1462 www.EquestrianTherapy.org

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: _____

Address (if different from above): _____

Phone: _____

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 o DO

o 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

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413-532-1462 www.EquestrianTherapy.org

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____

Address: _____

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 ____Therapeutic Equestrian 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 only be invoked if the person(s) above is unable to be reached

Consent Signature: _____ Date: _____
Client, Parent or Legal Guardian

Liability Release

_____ (*name*) would like to participate in the Therapeutic Equestrian Center's (TEC) program. I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the benefits are greater than the risks assumed. I hereby, intending to be legally bound, waive and release forever all claims for damages against The Therapeutic Equestrian Center, its Board of Directors, Executive Director, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses sustained while participating in TEC's program.

Under Massachusetts law, an equine professional is not liable for injury to, or the death of, a participant in equine activities resulting from the inherent risk of equine activities pursuant to *Section 2D of Chapter 128* of the General Laws.

Signature: _____ Date: _____
Client, Parent or Legal Guardian

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Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: _____
(center or therapist's name)

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

- o Medical history
- o Physical therapy evaluation, assessment and program plan
- o Speech therapy evaluation, assessment and program plan
- o Mental health diagnosis and treatment plan
- o Individual Habilitation Plan (I.H.P.)
- o Classroom Individual Education Plan (I.E.P.)
- o Psychosocial evaluation, assessment and program plan
- o Cognitive-behavioral management plan
- o Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

Please send materials to: _____

Therapeutic Equestrian Center

537 Northampton Street
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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

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 PathIntl center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Therapeutic Equestrian Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

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

Client Intake Form

Agency: ____Therapeutic Equestrian Center_____ Date: _____

Client Name: _____

Address: _____

Female Head of Household: Yes _____ No _____

Disabled: Yes _____ No _____

Hispanic: Yes _____ No _____

Race (must circle one): White Black Asian American Indian Pacific Islander Other/Mixed

Income: You must circle how many people are in your household AND
circle your household income under that column

Household Size	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8+ Persons
< 30% Very Low	$18,050 or below	$20,600 or below	$23,200 or below	$25,750 or below	$27,850 or below	$29,900 or below	$31,950 or below	$34,000 or below
< 50% Low	$30,100 or below	$34,400 or below	$38,700 or below	$42,950 or below	$46,400 or below	$48,850 or below	$53,300 or below	$56,700 or below
< 80% Moderate	$44,750 or below	$51,150 or below	$57,550 or below	$63,900 or below	$69,050 or below	$74,150 or below	$79,250 or below	$84,350 or below
Over 80%	$44,751 or higher	$51,151 or higher	$57,551 or higher	$63,901 or higher	$69,051 or higher	$74,151 or higher	$79,251 or higher	$84,351 or higher

Signatures are required

I certify that all the information on this form is true and correct and that all income is reported. I understand this information is being given for the receipt of federal funds, that the information on this application may be verified, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws. I also understand that this information will NOT be released to unauthorized persons.

_____ _____ _____ _____

Client Signature Date Staff Signature Date

Please Note

Due to our monitoring requirements with HUD if this form is incomplete it will not be entered as a new client

Thank You

Cliente Formulario de Admission

Agencia: ___Therapeutic Equestrian Center_____ Fecha: _____

Nombre de Cliente: _____

Direccion: _____

Numero de Personas en el Hogar: _____

Jefe de Familia Femenino: Si _____ No _____

Hispano: Si _____ No _____

Incapacidad: Si _____ No _____

Raza (circule uno): Blanco Asiatico Indio Americano Isleno del Pacifico Otro/Mixto

Debe circular cuantas son las personas de su familia Y
Circule con los ingreso de los hogares en la columna

Tamano de Familia	1 Persona	2 Personas	3 Personas	4 Personas	5 Personas	6 Personas	7 Personas	8+ Personas
< 30% Muy Baja	$18,050 o inferior	$20,600 o inferior	$23,200 o inferior	$25,750 o inferior	$27,850 o inferior	$29,900 o inferior	$31,950 o inferior	$34,000 o inferior
< 50% Baja	$30,100 o inferior	$34,400 o inferior	$38,700 o inferior	$42,950 o inferior	$46,400 o inferior	$48,850 o inferior	$53,300 o inferior	$56,700 o inferior
< 80% Moderado	$44,750 o inferior	$51,150 o inferior	$57,550 o inferior	$63,900 o inferior	$69,050 o inferior	$74,150 o inferior	$79,250 o inferior	$84,350 o inferior
En 80%	$44,751 o superior	$51,151 o superior	$57,551 o superior	$63,901 o superior	$69,051 o superior	$74,151 o superior	$79,251 o superior	$84,351 o superior

Frimas Requerida

Yo certifico que toda informacion en este formulario esta y es verdadera y que todo ingreso esta reportado. Yo entiendo que esta informacion es dada para recibir fondos federales, y que esta informacion puede ser verificada, y que la falsificacion deliberada de la informacion me puede haver sujeto a persecucion bajo las leyes estatales y federales. Yo tambien entiendo que la information NO sera divulgada a personas no autorizadas.

_____ _____ _____ _____

Firma del Cliente Fecha Firma del Personal Fecha

FOR FAVOR TENGA EN CUENTA
Debido a requisitos de monitoreo con HUD si este formulario está incompleto, no se introduce como un nuevo cliente
Gracias