



ANGELS ON HORSEBACK
A NARHA CENTER MEMBER PROGRAM

PARTICIPANT'S APPLICATION

Page 1 of 3

Participant's Name: _____ Date: _____

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

Mom (or other guardian): _____ Dad (or other guardian): _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Email: _____ Email: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

How did you hear about our program? _____

Describe any previous horse/riding experience: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

CONSENT PLAN: In the event emergency medical aid/treatment is required to due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize Angels on Horseback to:

- ★ Secure and retain medical treatment and transportation if needed.
- ★ Release client records upon request to 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.

NON -CONSENT PLAN: I **do not** give my consent for emergency medical aid. I will be **personally** responsible for any and all treatment decisions in the event of an emergency.

Date: _____

Signature: _____
Signed by Participant, Parent or Legal Guardian

*** PLEASE PROVIDE HEALTH INSURANCE INFORMATION ***

INSURANCE COMPANY NAME: _____

POLICY #: _____ **PHONE NUMBER:** _____

PREFERRED MEDICAL FACILITY: _____

PARTICIPANT'S APPLICATION

HEALTH HISTORY

Primary Diagnosis: _____ Date of onset: _____
 Secondary: _____ Date of onset: _____

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

	Yes	No	Comments
Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Communication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone/joint	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thinking/Cognition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please describe Participant's abilities/difficulties in the following areas, including details regarding assistance required or special equipment needed.

Physical Function (i.e. mobility skills such as transfers, walking, wheelchair use, driving, etc.) _____

Right handed

Left handed

Affected side: Right Left

Psycho/Social Function (i.e. work/school including grade completed, leisure interests, relationships/family structure, support systems, companion animals, fears/concerns, etc) _____

Preferred learning style(s): visual auditory hands-on

Medications (include prescription, over the counter, name, dose and frequency): _____

Allergies: _____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?) _____



PARTICIPANT'S APPLICATION

ANGELS ON HORSEBACK
A NARHA CENTER MEMBER PROGRAM

WAIVER AND RELEASE OF LIABILITY

Participant's Name: _____

--WARNING--

Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

I acknowledge that horseback riding or activities involving horses is an extreme test of a person's physical and mental limits and carries with it the potential for serious injury, personal property loss or even death. Horses are large animals and even the most quiet and calm horse can be unpredictable. I hereby assume the risk of participating in such activities.

I hereby take the following action for myself and my executors, administrators, heirs, next of kin, successors and assigns:

- a) I waive, release and discharge from any and all claims or liabilities for death, personal injury or damages of any kinds, which acts arise out of or relate to my participation in, or my traveling to and from, the horseback riding events, the following persons or entities: Angels on Horseback, Inc., its building or facility owners, sponsors, officers, directors, employees, volunteers, representatives, instructors, fieldhands, and agents of the above.
- b) I agree not to sue any of the persons or entities mentioned above for any of the claims or liabilities that I have waived, released or discharged herein, and
- c) I indemnify and hold harmless the persons or entities mentioned above from any claims made or liabilities assessed against them as results of my actions and any attorney fees or costs incurred by them as a result of my action.

I do do not consent to and authorize the use and reproduction by Angels on Horseback of any and all **photographs** and any other **audio/visual materials** taken of me for promotional material, educational, exhibitions or for any other use for the benefit of the center.

By signing this form, I affirm that I am of legal age (21 years of age or older), I have read this document, and I understand its contents. This document shall be construed under the laws of the State of Georgia.

Signature of Participant

Date

The undersigned _____, parent and natural or legal guardian of _____
name of parent or legal guardian
_____ hereby executes the foregoing Waiver and Release for and on behalf of
participant's name
the minor named herein. I hereby bind myself and all other assigns to the terms of the Waiver and Release. I represent that I have the legal capacity and authority to act for and on behalf of the minor named herein, and I agree to indemnify and hold harmless the persons and entities mentioned above for any claims or liabilities assessed against them as a result of any insufficiency of my legal capacity or authority to act for or on behalf of the minor in the execution of the Waiver and Release.

Signature of Parent or Legal Guardian

Date



ANGELS ON HORSEBACK
A NARHA CENTER MEMBER PROGRAM

PHYSICIAN'S STATEMENT

Page 1 of 3

Dear Health Care Provider:

Your patient is interested in or is participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the following three page Physician's Statement. Completed forms should be returned to your patient.

Patient's Name: _____ DOB: _____ Age: _____

Gender: Male Female Height: _____ Weight: _____ Pulse: _____ BP: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medications (type, purpose, & dose): _____

*If Down Syndrome, Atlanto-Axial Subluxation? Yes No

Results of Cervical X-ray for Atlanto-Axial Subluxation? Positive Negative X-ray date: _____

Date of last tetanus shot: _____

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing these forms, please note whether any of these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial Instability (include neurologic symptoms)
- Coxa Arthrosis
- Cranial Defects
- Heterotopic Ossification/Myositis Ossifications
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Join Fusion/Fixation
- Spinal Joint Instability/Abnormalities

Neurologic

- Hydrocephalus/Shunt
- Seizures
- Spina Bifida/Chiari II Malformation
- Tethered Cord/Hydromyelia

Other

- Age- under 4 years
- Indwelling Catheters
- Medications- i.e. photosensitivity
- Poor Endurance/Skin Breakdown

Medical/Psychological

- Allergies
- Animal Abuse
- Cardiac Condition
- Hemophilia
- Migraines
- Fire Setting
- PVD
- Recent Surgeries
- Substance Abuse
- Respiratory Compromise
- Thought Control Disorders
- Weight Control Disorders
- Medical Instability
- Blood Pressure control
- Dangerous to self or others
- Exacerbations of medical conditions (i.e. RA, MS)
- Physical/Sexual/Emotional Abuse

PHYSICIAN'S STATEMENT

PROBLEM	YES	NO	IF YES, DESCRIBE
Auditory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Glasses: _____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	_____
PVD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural Hypotension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Controlled?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last seizure: _____
Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shunt present?	<input type="checkbox"/>	<input type="checkbox"/>	# Revisions: _____
Sensory Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Contractures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Column Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Subluxing Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislocating Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laminectomy / Fusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Degree: _____ Type: _____ Brace: _____ Last X-ray: _____
Kyphosis / Lordosis	<input type="checkbox"/>	<input type="checkbox"/>	Degree: _____ Type: _____
Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heterotrophis Ossification	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cranial Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____ Healed? _____

PHYSICIAN'S STATEMENT

MOBILITY STATUS

Ambulatory

Yes

No

Can the student ambulate independently?

Yes

No

If no, please explain: _____

PROSTHETICS / ORTHODONTICS

Type: _____ Purpose: _____

Type: _____ Purpose: _____

OTHER:

Please indicate any medical problems not indicated above:

Please indicate special precautions:

PHYSICIAN'S STATEMENT

To my knowledge, there is no reason why _____ cannot participate in supervised equestrian activities. However, I understand that Angels on Horseback will weigh the medical information provided against the existing precautions and contraindications.

participant / patient's name

Physician's Printed Name: _____ MD DO NP PA Other: _____

Office Address: _____

Phone Number: _____ License/UPIN Number: _____

Physician's Signature: _____ Date: _____

Once completed and signed, please return **all three pages** of this Physician's Statement to your patient.

If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact Leslie Elliott at Angels at Horseback at the telephone number shown below.

Thank you very much for your assistance.