



**Hoofbeats For Hope**  
Changing Children's Lives...One Hoofbeat At A Time!!!



# Rider Packet



# Hoofbeats For Hope

Changing Children's Lives...One Hoofbeat At A Time!!!



## Authorization for Emergency Medical Treatment Form

Participant       Staff       Volunteer

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

### In the event of an emergency, contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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 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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

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



## **Participant Medical History & Physician Statement**

### **Part 1**

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 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 the attached form, please note whether these conditions are present, and to what degree.

#### **Orthopedic**

Atlantoaxial Instability – include neurological symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathological 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  
Poore 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 (ie. RA, MS)  
Fire Settings  
Hemophilia  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

**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 below.**

Sincerely,



## Participant Medical History & Physician Statement

### Part 2

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			
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. I understand that HOOFBELTS FOR HOPE will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to HOOFBELTS FOR HOPE for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_



## RIDER CONTACT INFORMATION FORM

**Name of Rider:** \_\_\_\_\_

**Mother/legal guardian:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Additional Contact Info: \_\_\_\_\_

**Father/legal guardian:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Additional Contact Info: \_\_\_\_\_

**Caregiver or any additional persons who are authorized to bring client to therapy:**

1. Name: \_\_\_\_\_ Relationship to Rider: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Additional Contact Info: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship to Rider: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Additional Contact Info: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship to Rider: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Additional Contact Info: \_\_\_\_\_



**PHOTO RELEASE FORM**

I  **DO**  
 **DO NOT**

Consent to and authorize the use and reproduction by HOOFBEATS FOR HOPE of any and all photographs and any other audio/visual material taken of me, or my child, for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Participant

\_\_\_\_\_  
Signature of Parent of Guardian

\_\_\_\_\_  
Date

(If participant is under 18 or unable to sign)



# Hoofbeats For Hope

Changing Children's Lives...One Hoofbeat At A Time!!!



## Release and Hold Harmless Agreement

I, \_\_\_\_\_ (Name of Participant), have the opportunity to participate in Hoofbeats for Hope Ltd., Co. Therapeutic Riding program at Hoofbeats for Hope Ltd., Co. Therapeutic Riding Center.

I understand that participating in equine activities, as a participant, rider, volunteer, student, spectator or staff, exposes me to a risk of property damage, personal injury or death. I understand that my choice of participating in equine activities is voluntary on my part, and I affirm my desire to participate in the program set out above. I agree to assume full responsibility for my safety and the safety of my property while I am in the arena or barn, in transit to and from the arena and at all other times. I understand that I may sometimes participate in various activities, some of which may include an element of risk.

In consideration of being allowed to participate in the above mentioned activity, I, the undersigned, and my Parent/Guardian, if applicable, do hereby release, indemnify, and hold harmless Hoofbeats for Hope, Ltd., Co. Therapeutic Riding Center, all the Center's officers, agents, employees and volunteers, any allied health, mental health professionals and any other professionals volunteering and/or contracting with Hoofbeats for Hope Ltd., Co. Therapeutic Riding Center or any other equine activity sponsor as well as other participants and spectators from any and all liability claims, demands, and actions whatsoever arising out of or related to any loss, damage, or injury, including death, which may be sustained by me or to any property belonging to me. The terms hereof shall also serve as a release and assumption of risk for my heirs, executor and administrator, and for all members of my family, and may be pleaded as a bar to litigation. Jurisdiction of this matter and venue shall lie exclusively in Slaughterville, Cleveland County, Oklahoma.

### WARNING

#### TITLE 76 O.S.A. SEC. 50.3 (THE OKLAHOMA LIVESTOCK ACTIVITIES LIABILITY LIMITATION ACT) STATES:

..... a livestock activity sponsor, a participant, or a livestock professional acting in good faith and pursuant to the standards of the livestock industry shall not be liable for injuries to any person engaged in livestock activities when such injuries result from the inherent risks of livestock activities.

I am 18 years of age or above (or my Parent/Guardian is also a signatory herein) and have read this Release and Hold Harmless Agreement and understand and voluntarily accept the terms.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Participant

### PARENT/GUARDIAN

(This section must be completed if participant is under 18 or legally incapacitated)

By signing herein, I acknowledge that I have read, understand and voluntarily agree to accept the terms of the above Release and Hold Harmless Agreement with respect to the above named Participant.

\_\_\_\_\_  
Signature of Parent/Guardian of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian