



"Healing With Horses"

JHTRA RIDER FORM

PHYSICIANS COMPLETE PAGES 1 and 2

PARENTS OR GUARDIANS COMPLETE PAGES 3, 4, and 5

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: + --
 Neurological 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 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: _____

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 **Page 1**, and Physician's Statement Form **Page 2**. 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

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 Setting
Hemophilia
Medical Instability
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Neurological

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

Name/Title _____

MD DO NP PA Other _____

Signature Date

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 above.

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____
Address: _____
E-mail 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 _____ JHTRA _____ 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: _____

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 of emergency treatment /aid is required, I wish the following procedure to take place.

Procedure: _____

Date: _____ Consent signature: _____

client, parent of legal guardian

Social (i.e. work/ school: leisure interests; relationships: family, support system, companion animals; fears/concerns)

Goals (i.e. what would you like to accomplish)

Liability Release

_____ (Rider's name) would like to participate in the Jackson Hole Therapeutic Riding Association's program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/son/daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Jackson Hole Therapeutic Riding Association, its Board Members, Executive Director, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/daughter/ my ward may sustain while participating in Jackson Hole Therapeutic Riding.

Date _____ Signature _____

Rider, Parent or Guardian

Photo Release (optional)

I hereby consent to and authorize the use and reproduction by Jackson Hole Therapeutic Riding Association of any and all photographs ,audiovisual materials, web site, taken of me/my son/ daughter/ my ward for the promotional printed materials, education activities or for any other use for the benefit of the program

Date _____ Signature _____

