



"Healing With Horses"

2012 JHTRA RIDER FORM

PHYSICIANS COMPLETE PAGE 1

PARENTS OR GUARDIANS COMPLETE PAGES 2, 3, and 4

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: _____

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 (Please check one)

I hereby _____ consent _____ do not 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 promotional printed materials, education activities or for any other use that may benefit JHTRA.

Date _____ Signature _____

Rider, Parent or Guardian

Payment Policy: Session fees are due before each session begins.

Rider Attendance Policy: If a rider misses a class there will not be a refund or a make-up class scheduled. If JHTRA cancels a class, there will be the choice of a make-up class or refund.

Exceptional Circumstances: JHTRA may approve prearranged absences in which exemption from riding appears to be in the best interest of the rider or the rider's family.

Parents or Guardian please initial you have read and understand these policies. _____

