Reindancer Therapeutic Riding Program

Application Packet

Laurita Equestrian Center
31 Archertown Road
New Egypt, NJ
609-752-0900

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Address: _____

Phone: _____ E-mail_____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset:_____

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency)

_____
_____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____

PSYCHOSOCIAL FUNCTION (e.g., 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: _____

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

- ☐ Medical history
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP)
- ☐ Classroom Individual Education Plan (IEP)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-behavioral management plan
- ☐ 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: _____

_____

_____

_____

This is an **initial letter** to your participant's physician. Attach the Participant's Medical History & Physician's Statement.

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 - e.g., 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 (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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.

Sincerely,
Reindancer Therapeutic Riding Center
609-752-0900

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 AtlantoAxial Instability: _____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	Yes	No	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 PATH Intl. Center for ongoing evaluation to determine eligibility for participation.
Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address:_____
Phone: ( )_____ License/UPIN Number: _____

Food/Environmental Allergy Notification

Name: _____

Parent/Guardian: _____

Date: _____

☐ I/My Child has/have **no** known allergies

☐ I/My Child has a food or environmental allergy

Please make note of any known food and/or environmental allergies that you/your child may have:

_____
_____
_____
_____

If you/your child has any allergies please provide special instructions as to treatment of a reaction:

_____
_____
_____
_____

☐ An Emergency Care Plan is attached.

_____ _____

Signature (Parent/Guardian if under 18) Date

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____ Phone: _____
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 *Reindancer Therapeutic Riding 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.

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.

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

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 emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____
_____
_____

Consent Signature: _____ Date: _____

Client, Parent or Legal Guardian

Laurita Equestrian Center, Reindancer Therapeutic Riding Program 501(c)3
31 ARCHERTOWN ROAD, NEW EGYPT, NJ 08533
www.LauritaEquestrianCenter.com
609-752-0900

RIDER AND VOLUNTEER REGISTRATION

Date: _____

Name: _____ DOB: _____ Age: _____

Street: _____ City: _____ State: ____ Zip: _____

Home Phone:_____ Work Phone: _____

Emergency Phone:_____ Email: _____

Parent or Guardian: _____ Phone: _____

LIABILITY RELEASE

_____ would like to participate in the Laurita Equestrian Center/Reindancer Therapeutic Riding Center Center (RDTRC), and I acknowledge the risks and potential of risks of riding and being around horses.

The Equine Activity Liability laws of the State of New Jersey, SS 5:15-3, state among its statutory provisions that "WARNING: UNDER NEW JERSEY LAW, AN EQUESTRIAN AREA OPERATOR IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ANIMAL ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ANIMAL ACTIVITIES, PERSUANT TO P.L. 1997, C287 (c. 5:15-1 et seq.)."

HOLD HARMLESS: In consideration of RDTRC undertaking the boarding, training, camps, lessons, and all relating services, the volunteer/participant/spectator agrees to hold RDTRC and its associates, assigns and agents, harmless from any claim resulting from damage or injury caused by animals, humans, or acts of nature to anyone, and agrees to pay any health or legal fees, and/or expenses incurred by RDTRC in defense of such claims.

CONFIDENTIALITY: In accordance with HIPPA regulations, I hereby agree to maintain the confidentiality of clients' personal information and health records, whether identified on paper or verbally.

I feel that the possible benefits 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 Charles Plum INC., RDTRC, its Board of Directors, instructors, staff, therapists, aides, volunteers, and/or employees for any and all injuries, and/or losses I/my child/my ward may sustain, any claims relating to negligent conduct, insufficient warning notices, failure to properly asses a participant's ability, or injuries sustained while under the influence of alcohol or drugs while participating in RDTRC INC.

Date: _____ Signature: _____

Client, Parent, or Legal Guardian

PHOTO/MEDIA RELEASE

I hereby **consent to** and authorize the use and reproduction by *Reindancer Therapeutic Riding Center* of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Print name: _____ Date: _____

Client/Parent/Legal Guardian consent signature: _____