Therapeutic Riding and Equine Assisted Activities for Children and Adults

Welcome!

Pony Power Therapies gives special needs and at-risk children and adults a unique opportunity to ride, care for and interact with horses. Our riding and non-riding activities enhance individuals' physical, social and emotional well-being in a safe, nurturing farm environment. We are a 501(c)3 registered nonprofit organization.

Pony Power is the only Professional Association of Therapeutic Horsemanship (PATH) International member center located in Bergen County. Because we implement PATH International standards, you can be assured that you will receive high-quality instruction in an environment that encourages participants to work toward fostering independence, enhancing individual strengths and achieving personal goals.

Rider Application Packet

Please read, complete, sign, and return the following forms 4 weeks prior to your first lesson.

- Participant Liability Release
- General Information
- Photo Release
- Health History
- Therapeutic and Safety Issues
- Physician's Statement and Medical History- **must be completed and signed by the participant's physician.**

You may also submit copies of the participant's IEP and therapy reports if applicable.

Please note that all riders must complete a new packet annually.

1170 Ramapo Valley Rd ♦ Mahwah, NJ 07430 ♦ 201-934-1001 ♦ 201-934-8891(FAX)
info@ponypowernj.org ♦ www.ponypowernj.org

Pony Power THERAPIES

PARTICIPANT LIABILITY RELEASE

Participant's Name: _____DOB: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

If Student, name of school: _____

In the event of Emergency, contact:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

_____ (Participant's name) would like to participate in the Pony Power Therapies, Inc. program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to my self, my son, my 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 Pony Power Therapies, Inc., its Board of directors, instructors, therapists, volunteers and/or employees for any and all injuries and/or losses I may sustain while participating in Pony Power Therapies, Inc.

Name (Print): _____ Date: _____

Signature: _____

(Client [over 18], Parent or Guardian)

Pony Power THERAPIES

GENERAL INFORMATION

Name: _____ DOB: _____

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

Ambulatory: □ Yes □ No □ With Assistance

Describe Ambulation Needs: _____

Communication: □ Verbal □ Non Verbal □ Communication Device □ Other

Describe Communication Needs: _____

Parent/Legal Guardian: _____

Address (**if different from page 2**): _____

Phone: _____

How did you hear about the program?: _____

PHOTO RELEASE

□ I DO □ I DO NOT

Consent to and authorize the use and reproduction by Pony Power Therapies of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Client (over 18), Parent or Legal Guardian

Pony Power THERAPIES

HEALTH HISTORY

What medications is the participant currently taking, including over-the-counter medications?

_____
_____
_____
_____
_____

Please describe the participant's functional abilities (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____

Please describe the participant's social structure/interests (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____
_____
_____
_____
_____

What goals would you like the participant to accomplish?

_____
_____
_____
_____
_____

Pony Power THERAPIES

HEALTH HISTORY continued

Diagnosis _____ Date of Onset _____

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

	Y	N	Comments
Allergies			
Behavioral			
Bone/Joint			
Breathing			
Circulation			
Communication			
Digestion			
Elimination			
Emotional/Mental Health			
Hearing			
Heart			
Muscular			
Pain			
Sensation			
Thinking/Cognition			
Vision			
Other			

THERAPEUTIC AND SAFETY ISSUES

Name: _____DOB: _____

Check and describe applicable issues (indicate current or history of):

- ☐ Aggressive
- ☐ Anxiety
- ☐ Boundary Issues
- ☐ Developmentally Delayed
- ☐ Emotional Abuse
- ☐ Fire Setting
- ☐ Hallucinations
- ☐ History of Animal Abuse
- ☐ History of Physical Abuse
- ☐ History of Runaway
- ☐ Hyperactivity
- ☐ Inattention
- ☐ Learning Disabilities
- ☐ Manipulative
- ☐ Mentally Challenged
- ☐ Phobias
- ☐ Possible Medication Side Effect
- ☐ Seizure Disorder
- ☐ Self-injurious Behavior
- ☐ Sensory Impairment
- ☐ Sexual Abuse/Acting Out
- ☐ Social Skills Problems
- ☐ Substance Abuse Problems
- ☐ Suicidal Ideations
- ☐ Tics or Stereotypic Behavior
- ☐ Unpredictable or Dangerous Behavior

Pony Power THERAPIES

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Thank you very much for your assistance, If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Orthopedic

Atlantoaxial Instability- include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Mositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
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
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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Pony Power THERAPIES

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____ Weight: _____
Street Address: _____ City: _____ State: _____Zip: _____
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: Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties 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			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications.

Name/Title: _____ MD DO NP PA
Signature: _____ Date: _____
Street Address: _____ Phone: ( ) _____
City:_____ License/UPIN Number:_____
State:_____
Zip:_____