Pony Power THERAPIES

Therapeutic Riding and Equine Assisted Activities for Children and Adults

Rider Application Packet

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

- Participant Liability Release
- General Information
- Mental Health Data Form (if applicable)
- Therapeutic and Safety Issues
- Participant's Consent for Release of Information
- Authorization for Emergency Medical Treatment
- Physicians Statement and Medical History. Must be completed and signed by physician.

It would be very helpful if you could send a copy of current IEP and therapy reports from your child's school or private therapist. Pony Power makes a concerted effort to coordinate and generalize our goals and objectives.

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

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PARTICIPANT LIABILITY RELEASE

Name:_____

Street Address:_____ **City:**_____

State:_____**Zip:**_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **Email:**_____

If Student, name of school: _____

_____ (Rider'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.

Date:_____

Name (Print):_____

Signature: _____ **(Client [over 18], Parent or Guardian)**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Please select one:
___Participant ___ Staff ___Volunteer

Name_____DOB_____Phone_____
Street Address:_____City:_____State:_____Zip:_____
Physicians Name_____Phone #_____
Preferred Medical Facility_____
Health Insurance Co._____Policy #_____
Allergies to medications_____
Current Medications_____

In the event of Emergency, contact:
Name_____Relation_____Phone_____
Name_____Relation_____Phone_____
Name_____Relation_____Phone_____

In the event emergency medical aid/ treatment are required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Pony Power 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.

Please sign one option:

1. 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_____ Signature_____
Client (over 18), Parent or Legal Guardian

2. Non-Consent Plan*

I do not give my consent for emergency medical treatment/and 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

Date_____ Signature_____
Parent or Legal Guardian

*** This option means parent or legal guardian must remain on site during all equine assisted activities.**

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GENERAL INFORMATION

Participant: _____
DOB:_____ Age: _____ Height: _____ Weight: _____ Gender: M F
Street Address: _____City:_____State:_____Zip:_____
Phone: _____ E-mail: _____ Alt. Number: _____
Employer/School: _____
Street Address: _____City:_____State:_____Zip:_____
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:

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

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GENERAL INFORMATION & HEALTH HISTORY *continued*

What medications are you currently taking, including over-the-counter medications? _____

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

Function (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

Social (i.e. 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?)

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THERAPEUTIC AND SAFETY ISSUES

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

__ inattention
__ hyperactivity
__ lack of concentration
__ learning disabilities
__ developmentally delayed
__ mentally challenged
__ boundary issues
__ social skills problems
__ problem with peers
__ separation anxiety
__ anxiety
__ phobias
__ aggressive
__ assaultive
__ manipulative
__ unpredictable or dangerous behavior
__ sensory impairment
__ sensitivity, preferences
__ tics or stereotypic behavior
__ psychosomatic symptoms
__ medical issues
__ self-injurious behavior
__ suicidal ideations
__ history of runaway
__ issues of parental support
__ issues of family support
__ sexual abuse/acting out
__ history of physical abuse
__ emotional abuse
__ hallucinations
__ delusions
__ illusions
__ dissociations
__ substance abuse problems
__ legal problems
__ school problems
__ history of animal abuse and/or __ fire setting
__ seizure disorder
__ possible medication side effect

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PHOTO RELEASE

Please select and sign one of the options below:

I DO ☐

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, Parent or Legal Guardian

Signed in the presence of center staff

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, Parent or Legal Guardian

Signed in the presence of center staff

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MENTAL HEALTH DATA

Client's Name: _____
Age: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____
Parent/Legal Guardian: _____ Phone: (H) _____ (W) _____
Street Address: _____City:_____State:_____Zip:_____
Physician: _____ Phone: _____
Therapist: _____ Phone:_____

Diagnosis (DSM-IV)

Axis I_____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Presenting Problems

_____
_____
_____
_____
_____

Current Medications

Drug	Dose	Route	Time	Purpose

_____

Psychiatric Treatment History

	Where	When	Diagnosis Current
Therapy Outpatient			
Therapy Inpatient			

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____
(person or facility)

To release information from the records of: _____ DOB: _____

The information is to released to: _____
(center or therapist's name)
For the purpose of developing a therapeutic riding/equine activity program for the above named participant. The information to be released is marked below.

__ Medical History
__ Physical Therapy evaluation, assessment and program plan
__ Occupational Therapy evaluation, assessment and program plan
__ Speech Therapy evaluation, assessment and program plan
__ Classroom Individual Education Plan (IEP)
__ Psychosocial evaluation, assessment and program plan
__ Cognitive behavioral management plan
__ Other: _____

Signature: _____ Date: _____

Please send materials to: _____
_____
_____
_____

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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 above.

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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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: AtlantoDens Interval X-rays, date: _____ Result: + --
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. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

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

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