DISCOVERY RIDERS, INC.

Year: _____

P.O. Box 217
Bellefontaine, Ohio 43311
937-935-6545

Session: _____

Participant's Application and Health History

(Must be returned at least 2 weeks prior to the first class)

GENERAL INFORMATION

Participant:_____

DOB:_____ Age:_____ Height:_____ Weight:_____Sex: M F

Address:_____

Phone #:_____ Alternative #:_____

Employer/School:_____

Address:_____Phone#:_____

Parent/Legal Guardian:_____

Address (if different from above):_____

Phone#:_____Email:_____

How would you prefer to be contacted? (Email, texting, calling, all three?)_____

Referral Source:_____

Contact Numbers:_____

How did you hear about the program?_____

What days would you prefer for class? (circle) Mon Tues Wed Thur Fri Sat - underneath put 1st, 2nd, 3rd choices

PHOTO RELEASE

- ❑ I DO
- ❑ I DO NOT

Consent to and authorize the use and reproduction by Discovery Riders, Inc. 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

HEALTH HISTORY

Please indicate current or past problems in the following areas: **DIAGNOSIS**_____

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

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

_____

_____

_____

Is there a history of seizures? _____ If so, type _____Date/Last seizure _____

Warning signs: _____

_____

(Continued)

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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)

_____

_____

_____

_____

_____

Horse Experience (i.e. Have they ever been around horses? How many years? Type?)

_____

_____

_____

_____

_____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

_____

_____

_____

_____

_____

Discovery Riders

P.O. Box 217 Bellefontaine, Ohio 43311

937-935-6545

AUTHORIZATION for EMERGENCY MEDICAL TREATMENT FORM

☐ Participant ☐ Staff ☐ Volunteer

Name:_____ DOB:_____ Phone:_____

Address:_____

Physician's Name:_____ 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 Discovery Riders, Inc. 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: The 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:_____

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. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date:_____ Consent Signature:_____

Client, Parent or Legal Guardian

DISCOVERY RIDERS, INC.

P.O. Box 217

Bellefontaine, Ohio 43311

937-935-6545

Date:_____

Dear Physician:

Your patient,_____ (participant's name) is interested:

_____ Supervised equestrian activities
_____ Therapeutic horseback riding lessons
_____Hippotherapy with a licensed Physical, Occupational, or Speech Therapist

In order to safely provide this service, we request 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.

ORTHOPEDIC

Atlantoaxial Instability
– include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis 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

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medial conditions
Fears
Heart Conditions
Hemophilia
Medical instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Weight Control Disorder

OTHER

Indwelling Catheters Medications – i.e. photosensitivity Skin Breakdown

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 us.

Sincerely,
Adam Judd, Executive Director 937-935-6545

DISCOVERY RIDERS, INC.

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**:* Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. 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:_____

.PATH Intl. Standards for Certification & Accreditation

PERMISSION TO PARTICIPATE IN DISCOVERY RIDERS' THERAPEUTIC RIDING PROGRAM, DISCLOSURE, RELEASE OF CLAIMS, CONSENT TO EMERGENCY MEDICAL TREATMENT AND INDEMNIFICATION

I, _____("Participant"), have chosen to participate in the Discovery Riders Therapeutic Riding Program ("Program") and its related horse activities. I _____ (parent or guardian) have chosen to allow Participant to participate in Program.

I am aware that:

A. Horses have a tendency to behave in ways, which may result in injury, death, or loss to riders, or other persons in the immediate vicinity;
B. Horses may react in an unpredictable way to sounds, sudden movement, unfamiliar objects, persons, or other animals;
C. Riding a horse may give rise to a risk of injury from hazards arising from the surface or subsurface of the ground in which these riding activities occur;
D. While in the vicinity of a horse or while riding a horse, I may be involved in a collision with another horse, another animal, a person, or an object;
E. Other individuals in the program may fail to maintain control over a horse or fail to act within their abilities, thus causing harm to me or other individuals; and
F. Other individuals in the program may act in a negligent manner, which could result in harm to me.

As parent or guardian I have discussed with individual the need to behave in a safe manner. I will make sure that individual wears appropriate clothing and footwear during horse activities and other program activities.

In consideration for the opportunity to participate in Program activities and the use of services and facilities made available through these Program activities, I do release and forever discharge for myself and my heirs, executors, administrators, and assigns, and for individual and individual's heirs, executors, administrators and assigns, the leaders, agents, employees, volunteers, directors, officers, administrators, faculty and staff, of Discovery Riders, from all claims, demands, and causes of action for personal injury or any other damage which may arise out of or be in any way related to individual's participation in Program.

I grant individual permission to participate in Program and its related horse activities despite the possible risks. I recognize that by participating in these activities, as with any physical activity, individual may risk personal injury. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in these activities, and that I assume any expense that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses. As a parent/guardian, I assume the same risk for myself, and other family members and friends present at these Program activities.

In the event of emergency or injury to individual requiring immediate medical attention for individual , I hereby consent to emergency medical treatment, including transportation to medical providers, for individual .

I agree to indemnify and hold harmless Discovery Riders for any claims, damages, or causes of action arising from individual's conduct and/or participation in Program.

Signed_____ Dated_____ Signed_____ Dated_____

(Parent or Guardian)

FINANCIAL AGREEMENT

Each Therapeutic Riding Session is 6 weeks long, one hour per week. The cost is $240 for each 6 week session payable the first class of each session, unless other arrangements are made.

Please indicate any funding source that is available to the class participant:

____ county – name of agency _____

____ state – name of agency _____

____ private scholarship – name of donor _____

____ grant through school _____

____ other _____

There is a limited amount of scholarship and United Way money available through Discovery Riders Inc. Please indicate if you are interested in applying for these funds. ____ yes ____ no

Families of the class participants are responsible for session costs. The costs of the Therapeutic Riding classes are not reimbursable by insurance companies.

Please indicate where you would like the session invoice to be sent and to whose attention:

_____

_____

_____

_____

Participant Name _____ Date_____

Signature _____Relationship_____

Discovery Riders, Inc.
Therapeutic Riding
APPLICATION FOR FINANCIAL ASSISTANCE

Fill out the following information and return to the Executive Director of Discovery Riders, Inc. Discovery Riders will grant financial aid to the extent that funds are available. Discovery Riders reserves the right to refuse assistance to any applicant. All records are confidential. Please type or print the information.

Date of Application: _____ Social Security Number: _____

Name: _____ Home.Cell Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Pace of Employment: _____ How long employed: _____

Age: _____ Birth Date: _____

Spouse/Child(ren)	Age	School/Employer	Birth Date

Are you a single parent household? ____ Yes ____ No

Your present income level is: ____ Under $8,000

____ $8,001 to $12,000

____ $12,001 to $15,000

____ $15,001 to $18,000

____ $18,001 to $20,000

____ $20,001 to $25,000

____ $ Over $25,000

(Contined)

Please itemize your monthly income and expense items

INCOME		EXPENSE	
Wages, salaries and tips	$ _____	Rent/Mortgage	$_____
Unemployment Compensation	$ _____	Utilities	$ _____
Social Security Compensation	$ _____	Food	$ _____
Aid to Dependent Children	$ _____	Clothing	$ _____
Food Stamps	$ _____	Phone	$ _____
401K Retirement Funds	$ _____	Car/Insurance	$_____
Alimony	$ _____	Alimony	$ _____
Child Support	$ _____	Medical	$ _____
Other	$ _____	Child Support	$ _____
		Other	$ _____

Total Income $ _____Total Expense $_____

Note:

How much do you feel you can afford per 6 week session? _____