Riding with HEART
639 County Rd 513
Pittstown, NJ 08867
(908) 735-5912

Participant's Application and Health History

Participant Name: _____ Date: _____

Birth Date: _____ Age: _____ Height: _____ Weight: _____ M / F

Parent/Legal Guardian Name and Address: _____

_____

Best Contact Phone: _____ Alternative #_____

Email Address: _____

Employer/School: _____

How did you learn about the program? _____

Liability Release

I / my child would like to participate in the Riding with HEART program. I acknowledge the risks and potential for risks of horseback riding and working around horses. However, I feel the possible benefits to me / my child 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 Riding with HEART, its Board of Directors, Affiliated Organizations, Employees, Instructors, Therapists, Aides, Volunteers, Equines and Operating Site for any and all injuries and/or losses I / my child may sustain while participating in Riding with HEART activities.

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, PURSUANT TO P.L. 1997, C.287, C:5:15-1 ET ESQ.

Print Name: _____

Signed: _____Date: _____

(Signature of parent/guardian if volunteer is under 18 years of age)

Photo/Media Release/Website

☐ I DO

☐ I DO NOT

Consent to and authorize the use and reproduction by Riding with HEART of any and all photographs and any other audio/visual materials taken of me/my child for promotional material, educational activities and exhibitions or for any other use for the benefit of the program.

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Health/Medical History

Participant Name: _____

Diagnosis: _____

_____

Please complete the following which addresses special needs and/or concerns to bring to our attention:

	YES	NO	COMMENTS
VISION			
HEARING			
SENSATION			
COMMUNICATION			
HEART			
BREATHING			
DIGESTION			
ELIMATION			
CIRCULATION			
EMOTIONAL			
BEHAVIORAL			
PAIN			
BONE/JOINT			
MUSCULAR			
THINKING/COGNITION			
NEUROLOGICAL			
ALLERGIES			
DOWN SYNDROME			
LEARNING DISABILITIES (Specify)			
OTHER			

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

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FUNCTIONAL (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)

_____

_____

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

_____

_____

_____

PARTICIPANT'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant Name: _____ Date of Birth: _____ Phone: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy Number: _____

Allergies: (medications and other): _____

Medical Conditions / Diagnosis: _____

Current Medications: _____

_____

In the Event of an Emergency Contact:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

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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 Riding with HEART, I authorize RWH Program to:

1. Secure and retain medical treatment and transportation if needed.
2. Release pertinent 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 "lifesaving" by the physician. This provision will only be invoked if the emergency contact(s) above is (are) unable to be reached.

Consent Signature: _____ Date: _____
(Parent/legal guardian)

OR

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury while I/my child participate in Riding with HEART. In the event emergency treatment/aid is required, I wish the following procedure to be followed:

_____

_____

Print Name _____

Non-Consent Signature: _____ Date _____
(Parent/legal guardian)

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PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Dear Physician,

Your patient, _____ would like to participate in supervised equestrian activities at Riding with HEART.

In order to safely provide this **service of horseback riding and horse related activities**, our program requests that you complete/update this Medical History and Physician's Statement form.

Participant Name: _____ Date of Birth: _____ Height: _____ **Weight: _____

Diagnosis: _____ Date of onset: _____

Past/Prospective Surgeries (dates): _____ Fractures (dates): _____

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 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
Atlanto Axial Instability – include neurologic symptoms
Coxarthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/fixation
Spinal Instability Abnormalities

NEUROLOGIC
Medical Instability
Migraines
Hydrocephalus/Shunt
Seizure/Respiratory Compromise
Spina bifida/Chiari II Malformation/Tethered Cord/Hydromyelia
Substance Abuse
Thought Control Disorders

MEDICAL/PSYCHOLOGICAL
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Down Syndrome
Exacerbations of medical conditions
Fire Setting
Heart Conditions
Hemophilia

OTHER
Weight Control Disorder
Recent Surgeries
Under the age of four
Indwelling Catheters
Medication Photosensitivity
Poor Endurance
Skin Breakdown

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Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	IF YES PLEASE SPECIFY
AUDITORY			
VISUAL			
TACTILE SENSATION			
SPEECH			
CARDIAC			
CIRCULATORY			
INTEGUMENTARY/SKIN			
IMMUNITY			
PULMONARY			
NEUROLOGIC			
MUSCULAR			
BALANCE			
ORTHOPEDIC			
ALLERGIES			
LEARNING DIASBILITY (please specify)			
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, PT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ Lic. /UPIN Number: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____ Phone: (_____) _____