Participant Application Check List

Name of participant: Date:

Please check what applies to you:

1. I will pay full amount ☐
2. I require financial assistance (see page 11 in application packet) ☐
3. Tuition will be paid by Far Northern Regional Center ☐
4. Tuition will be paid by other party. Name: ____________________ ☐

Cost Per Session
Spring: $320.00
Summer: $240.00
Fall: $320.00

- **Ensure ALL your forms are being submitted (or have been submitted) and are up to date**
- **For enrollment to be complete payment is required along with registration**
- **If you are having a third party pay it is <u>your</u> responsibility to make the arrangements *before* enrolling**

If you have any questions or need any assistance please call our office (530) 842-3082 or email us at info@stablehands.org

Participant's Application & Health History

GENERAL INFORMATION

Participant: ____

DOB: ________________ Age: ______ Height: ______ Weight: ______ Gender: M F

Address: ____

Phone: ________________ Email: ____________________ Alternative #: ________________

Employer/School: ____

Address: ____

Phone: ____

Parent/Legal Guardian: ____

Caregivers: ____

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			

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: ____________________

PATH INTERNATIONAL
Premier Accredited Center
Professional Association of Therapeutic Horsemanship International

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			
Emotional/Psychological			
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

Signature: ______________________________ Date: ____________________

Phone: (______) ____________________ License/UPIN Number: ____________________

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,

____

Name *Center Name* *Phone Number*

MEDICAL HISTORY & EMERGENCY TREATMENT RELEASE INFORMATION

Name: ________________________ ____________________ **Date of Birth:** _________________
Last First

Height: __________________ **Weight:** _____________

MEDICAL INFORMATION

Physician: ____

Address:____ Hospital:_________________

Medical Insurance Company:____

Address:____

Policy Number: ______________________ group # ________________

Company or Agent Phone: ___________________________

Medical History

Allergies:____

____

Current Medications:____

____

Please describe your current health status, particularly regarding the physical/emotional demands of working in an equine-assisted program. Address fitness, cardiac, respiratory, bone or joint function, recent hospitalizations and/or surgeries, or lifestyle changes____

____

____

____

____

____

____

IN CASE OF EMERGENCY:

Notify: ____ Phone: ____________________________

Address: ____ Relationship: ____________________

Or,

Notify: ____ Phone: ____________________________

Address: ____ Relationship: ____________________

Or,

Notify: ____ Phone: ____________________________

Address: ____ Relationship: ____________________

Consent Plan

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 Stable Hands 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.

This authorization includes radiography, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Consent signature:____ Date:________________

Parent/Legal Guardian:____

Non-Consent Plan

I DO NOT give my consent for emergency medical treatment/aid in the case of illness of injury during the process of receiving services or while being on the property of the agency.

- ***Parent/legal guardian or caregiver will remain at activity site at all times during equine assisted activities.***

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

____

____

Non-Consent signature:____ Date:________________

Parent/Legal Guardian:____

Release, Hold Harmless and Assumption of the Risk Agreement

I,______________________________(print name) would like to participate in the Stable Hands equine assisted activity program (the "Program"). In exchange for the privilege of participating in the Program, I agree that neither I nor my family, nor any legal guardian, heir or assignee, will sue or make a claim against Stable Hands, the Eastman/Sander Facility or attach the property of Stable Hands or the Eastman/Sander Facility for death, injury or damage resulting from any act or omission, whether the injury or the damage occurs by act of negligence or any other act by human, by physical condition of the property or by animal. I understand that I am releasing and holding Stable Hands and the Eastman/Sander Facility harmless from any and all claims, demands or actions that I, my family, my heirs or any legal guardian, assignee or legal representative may have now or may have in the future for any death, injury or damage resulting from my participation in the Program or any other activities at Stable Hands, on the Eastman/Sander Facility or other site. **I am fully aware that I am assuming any and all risks associated with the Program and any other activities at Stable Hands.** I am fully aware that there are many risks and dangers involved in participation in the Program and other activities at Stable Hands, and I agree to accept the consequences of such risks, including, but not limited to, the risk of injury, death, and damage to personal property. I am also fully aware that only Service Dogs are allowed on the Eastman/Sander Facility and that they must be kept in the vehicle at all times, unless they are in the act of assisting a rider. If I do not fully understand the risks, I will consult with a staff member immediately. **If I do understand the risks associated with my/my child's participation, I will verify that I do understand the risks by placing my initials here: ______**

____**I DO** have a "Service Dog" that will/may attend lessons at the Eastman/Sander Facility.

____**I DO NOT** have a "Service Dog".

____ ___________________

Signature Date

____ ___________________

Signature of parent/guardian if a minor Date

Volunteer/Staff/Participant Photo Release

Name: ____

Date of Birth:____

PHOTO RELEASE

I **( ) DO**

( ) DO NOT

consent to and authorize the use and reproduction by **Stable Hands** of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program (to include, but not limited to brochure, Stable Hands' webpage or Facebook page, video on our Website via hosted through YouTube, Vimeo, DVD or presentations) .

Signature: ____Date: ____________

Participant, Parent or Legal Guardian
(Volunteer or Staff)

Client Parent/Caregiver Information

Client Name: ____ Date: ______________

Parent/Caregiver Information

Name of Parent or Caregiver: ____

Address: ____

Telephone: ____

Email Address: ____

Preferred method of contact: _____Text ______Phone Call

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STABLE HANDS FINANCIAL ASSISTANCE APPLICATION

Date of application: ______________________________

Request for: ☐ All Sessions ☐ Spring Session ☐ Summer Session ☐ Fall Session

Participant Name: ____

Parent, Guardian or Caregiver Name:____

Phone Number: (daytime) ______________________________ (evening) ______________________________

1.) **What portion of your session tuition are you able to pay?**

☐ Fall/Spring $320.00 (100%) ☐ $160.00 (50%) ☐ $105 (33%) ☐ $50.00 (minimum) ☐ Other: ____

☐ Summer $240.00 (100%) ☐ $120.00 (50%) ☐ $79 (33%) ☐ $50.00 (minimum) ☐ Other: ________

Pay in ☐ 1 ☐2 ☐3 Installments (Payments due before start of each session)

2.) **Please check the category of TOTAL HOUSEHOLD <u>NET</u> income from ALL sources (work, government/family support, trust, dividends, etc.):**

☐ up to $15,000 ☐ $15,000-$30,000 ☐ $30,000-$45,000 ☐ $45,000-65,000

3.) **TOTAL number of persons/dependents in your household:** __________________

4.) **Please discuss factors contributing to financial hardships (i.e.: single parents, large household, medical costs, fixed income, etc.) and/or special circumstances:**

____

____

____

5.) **Please tell us how participating in Stable Hands would benefit you or your rider/client:**

____

____

____

____

____

____

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Preferred Scheduling Form

Client: ________________________________ **Phone #:** ______________________________

Height____________ Weight_____________ Age_______________

I am able to participate on the following days:

_____ Tuesdays

_____ Thursdays

_____ I can attend either day.

I am able to participate at the following times:

_____ 10:30 AM _____ 12:15 PM

_____ 2:30 PM _____ 4:15 PM

My **first** choice to be scheduled is on __________________________ at _____________________.
(DAY) (TIME)

My **second** choice to be scheduled is on __________________________ at _____________________.
(DAY) (TIME)

My **third** choice to be scheduled is on __________________________ at _____________________.
(DAY) (TIME)

☐ **Please check here if Medical History & Physician's Statement is Current & Submitted.**

(Scheduling Priority will be given to complete & current Rider Applications)