Stable Hands

HEARTS, HANDS AND HORSES - BUILDING DREAMS, CHANGING LIVES

PATH INTERNATIONAL

Stable Hands P.O. Box 1852 Yreka CA 96097 (530) 842-3082 www.stablehands.org

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ E-mail: _____ Alternative phone: _____

HEALTH HISTORY

Primary Diagnosis: _____ Secondary Diagnosis (_____

Date of onset: _____

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

	Y	N	Comments
Auditory			
Visual			
Sensations			
Speech/Communications			
Heart/Cardiac			
Breathing			
Digestion			
Elimination			
Muscular			
Circulation			
Bone & Joint			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
Pain			
Other			

Military Service History (Branch of service; **when and where did you serve; what was your military job specialty)**

Please describe abilities/difficulties in the following areas (include assistance required or equipment needed).

Function (Mobility skills such as transfers, walking, wheelchair use, driving a car)

Psycho/Social (Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, concerns etc.)

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

Do you have experience with horses? If yes, please describe.

Signature: _____ Date: _____

Veteran, or Legal Guardian

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PATH INTERNATIONAL

Professional Association of Therapeutic Horsemanship International

Participant's Medical History & Physician's Statement

Participant: _____ D.O.B.: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ ICD10 _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Yes No Date of Last Seizure: _____

Shunt/Pacemaker or implanted device present: Yes No Type: _____

Special Precautions/Needs: _____

_____

Mobility: Ambulates independently With walker or cane Uses wheelchair

Prosthesis/Assistive Devices: _____

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

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

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/Myosistis 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 medical conditions
Fire Setting
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

OTHER

Age – under 4 yrs
Indwelling catheters
Photosensitivity
Poor Endurance
Skin Breakdown

Veteran Name:_____

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: _____

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 and therapy 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

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PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

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)