



Equi-Ed

Equines and Education

Mailing address: 1535 Farmer's Lane #217 Santa Rosa, CA 95405

Message: (707) 5-HORSES Fax: (707) 942-0915 Website: www.equi-ed.org

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

General Information

Participant: _____

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

Diagnosis: _____

Address: _____

Phone: _____ Cell # _____ Email: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address: (if different from above) _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

(If Applicable) Agencies or individuals with which they are connected/receiving support from: _____

(If Applicable) Toileting needs: _____

(If Applicable) Verbal _____ Non-Verbal _____ Signs? _____ Mental Age _____

Health History

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, over-the-counter; name, dose and frequency) _____

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

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

Psycho/Social Function (i.e. Work/school including grade completed, leisure interests, companion animals, fears/concerns, etc) _____

Discuss Social Relationships/Support Systems:

With family members (please include names and ages) _____

With peers: _____

Any specific behavioral issues or concerns: _____

Is there a behavioral management plan in place? Yes No

If yes, please describe. _____

Goals (i.e. What is the reason for your interest to participate in therapeutic riding? What would you like to accomplish?) _____

*****SIGNATURE NEEDED*****

Signature of person completing health history form

Title/Relationship to client

Date

Equines and Education

E-mail: equiedinc@aol.com web site: www.equi-ed.org

Phone (707)953-6223 Message 5-HORSES

Equi-Ed is a state and federally recognized non-profit, tax exempt organization under IRS regulation 501(c)3.

Donations are tax deductible according to the extent of the law.

Federal Tax Identification #68-0356989

CONSENT FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

I, the undersigned, request the appropriate person and/or agency or institution to release information to EQUI-ED for the purpose of developing a Therapeutic Riding Program Plan. All information will be kept confidential and maintained as part of student records with Equi-Ed. I hereby authorize the release of information which may include one or more of the following:

- Medical History
- Physical Therapy Evaluation, Assessment, and Program Plan
- Occupational Therapy Evaluation, Assessment, and Program Plan
- Speech Therapy Evaluation, Assessment, and Program Plan
- Psychological Evaluation, Assessment, and Program Plan
- Classroom Individual Education Plan (I.E.P.)

I further give permission for EQUI-ED certified staff to discuss the student's therapeutic riding situation with other staff and professionals who have a legitimate need to know such information.

This authorization shall remain in effect while a client with EQUI-ED or until revoked in writing.

Signature

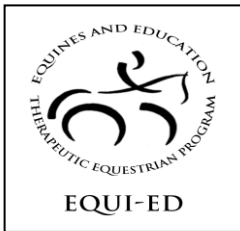
Date

Signature of Parent/Guardian if under 18

Date

Please note: This information will assist our program in planning an effective riding therapy program. The client has a right of access to any information you may provide as a result of this release.

A photocopy of this is as valid as the original.



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Name: _____ Birthdate: _____
Address _____ City : _____ Zip _____
Parent/Guardian/Spouse/Other (specify relationship _____) _____
Home Phone: _____ Cell _____ Work Phone _____ Email _____
In Emergency Contact: _____ Phone # _____

LIABILITY RELEASE:

WHEREAS, the undersigned acknowledges the inherent risks involved in riding and working with horses, which risks could include bodily injury from using, riding, or being in close proximity to horses, among other risks, and further, that both horse and rider or the volunteer assisting them can be injured in normal use or in competition or schooling (horses are unpredictable by nature, when frightened or angry or under stress, a horse's natural instincts are to jump forward or sideways, to run away from danger at a trot or gallop, to kick, to buck, to rear up in front, or to bite; horses are extremely powerful; and if a rider falls to the ground, the fall distance will be generally from 3 to 5 feet).

I understand these risks, and I voluntarily assume these risks and dangers with the feeling that the potential benefits to myself/my son/daughter/my ward are greater than the risk assumed.

IN CONSIDERATION, therefore, for the privilege and personal desire to take riding lessons and/or be with horses in the Equi-Ed Therapeutic Riding Program, whose instruction or related activities are held at: 4650 Petrified Forest Rd, Calistoga, CA 94515
1218 Bennett Lane, Calistoga, CA.
Cresta Ranch 3000 Porter Creek Road, Santa Rosa, CA
and/or the SRJC Shone Farm, Forestville, CA

the undersigned does hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, agrees to hold harmless and indemnify Equi-Ed, and Santa Rosa Junior College, its directors, instructors, therapists, students, other volunteers, and the owners of 1218 and 1310 Bennett Lane, Calistoga, CA and further release any of them from any liability or responsibility for accident, damage, injury, illness or death to the Undersigned or to any horse owned by the Undersigned while under the direction, instruction or participation in any aspect of the Equi-Ed Therapeutic Riding Program.

Date: _____ 20____
Student/Staff/Guest/Volunteer Signature

Date: _____ 20____
(Parent/Guardian Signature if under 18)

PHOTO RELEASE (Optional): I HEREBY CONSENT TO AND AUTHORIZE THE USE AND REPRODUCTION BY EQUI-ED OF ANY AND ALL PHOTOGRAPHS AND ANY OTHER AUDIOVISUAL MATERIALS TAKEN OF ME/MY CHILD/MY WARD FOR PROMOTIONAL PRINTED MATERIAL, EDUCATIONAL ACTIVITIES, EXHIBITIONS OR FOR ANY OTHER USE FOR THE BENEFIT OF THE PROGRAM.

Date: _____ 20____
Student/Staff/Guest/Volunteer Signature

Date: _____ 20____
(Parent/Guardian Signature if under 18)

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STAFF/VOLUNTEER/STUDENT/GUEST/PARTICIPANT EMERGENCY HEALTH INFORMATION

In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in

services/activities, or while being on the property of the agency, I authorize Equi-Ed/SRJC to:

1. Secure and retain medical treatment and transportation if needed.
2. Release staff/volunteer/client/participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name: _____ Phone # _____

Parent/Guardian/Spouse/Other (specify relationship _____) _____

Address _____ City : _____ Zip _____

Allergies: _____

Medications: _____

Please describe any other medical conditions/physical limitations that we or medical personnel should be aware of i.e.

seizures, diabetes, etc.:

Emergency Contacts:

Name _____ Phone (H) _____ Phone (W) _____

Name _____ Phone (H) _____ Phone (W) _____

Physician's Name _____ Phone _____

Preferred medical facility _____

Insurance Company _____ Phone _____

Full Address _____

Group # _____ Policy # _____

Medi-Care # _____ Medi-Cal # _____

*****SIGNATURE NEEDED BELOW*****

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 listed below is unable to be reached.

Consent signature (self/parent/guardian) _____ Date: _____

Print Name: _____ Phone: _____

Address: _____

OR

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness/injury during the process of participating in the services or while on the property of the agency. In the event emergency treatment/aid is required, I

wish the following procedures to take place:

Non-Consent Signature (self/parent/guardian) _____ Date: _____

Print Name: _____ Phone: _____

Address: _____