Rider Application Packet

Participant's Application and Health History

To be completed by the participant or parent/legal guardian/caregiver. Please complete clearly and completely.

Participant: _____ **DOB:** _____

Race: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Gender:** M F

Please include your household income range as this data is required for many grant applications. This information will only be used for this purpose unless otherwise notified.

Household Income: $0-$20,000_____ $21,000-$40,000 _____ $41,000-$75,000_____$75,000-$100,000_____Over $100,000_____

Government Assistance or Outside Funding Received (Ex: SSI, Medicare, Medicaid): _____

Address: _____

County of Residence: _____

Parent/Legal Guardian/Caregiver: _____

Parent/Guardian Address (if different from above): _____

Best Phone #: _____ **Name at #:** _____**Type of #:** ☐Home ☐Cell ☐Work

Alt./Guardian Phone #: _____ Name at #: _____Type of #: ☐Home ☐Cell ☐Work

E-mail: _____ **Name of E-mail recipient**: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone Call ☐ Text ☐Work Phone ☐Email

Text Message Opt In: ☐ No ☐ Yes Encouraged for last minute cancellations! Text Phone #: _____

Participant Employer/School: _____ Participant Occupation: _____

Parent's Employer and Occupation: _____

Parent's Employer and Occupation: _____

☐ Please do not solicit me for funds on behalf of MTR ☐ Please do not include me on the MTR mail list for general information

How did you hear about the program?/Referral Souce_____

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			

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MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)* _____

_____

_____

_____

_____

Describe your 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, 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?)

_____

_____

_____

_____

_____

_____

PHOTO RELEASE

I ☐DO

☐DO NOT

consent to and authorize the use and reproduction by _____ of any and all photographs and any other audio/visual materials taken of me for promotional material, social media, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

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	**Medical/Psychological**
Atlantoaxial Instability - include neurologic symptoms	Allergies
Coxa Arthrosis	Animal Abuse
Cranial Deficits	Cardiac Condition
Heterotopic Ossification/Myositis Ossificans	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to self or others
Pathologic Fractures	Exacerbations of medical conditions (i.e. RA, MS)
	Fire Settings
Spinal Joint Fusion/Fixation	Hemophilia
Spinal Joint Instability/Abnormalities	Medical Instability
	Migraines
Neurologic	PVD
Hydrocephalus/Shunt	Respiratory Compromise
Seizure	Recent Surgeries
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia	Substance Abuse
	Thought Control Disorders
Other	Weight Control Disorder
Age - under 4 years	
Indwelling Catheters/Medical Equipment	
Medications - i.e. photosensitivity	
Poor Endurance	
Skin Breakdown	

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,

Kelly Rodgers

_____
Program Director
410.923.6800
Maryland Therapeutic Riding, Inc.
1141 Sunrise Beach Road
Crownsville, MD 21032

Participant's Medical History & Physician's Statement

Participant: _____**DOB**: _____ **Height**: _____ **Weight**: _____

Diagnosis: _____ **Date of Onset**: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ **Controlled:** Y N **Date of Last Seizure**:_____

** If there has been seizure activity in the last 10 years, please complete MTR's Seizure Statement and include with the completed Rider Application Packet*

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: Result of Neurologic exam for Atlantoaxial Instability: ☐ Present ☐ Absent

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equine activities. However, I understand that the PATH Intl. 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, OT, SLP, Psychologist, etc.) in the implementation of an effective equine activity program.

Name/Title: _____ MD DO NP PA Other _____
Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____

Authorization for Emergency Medical Treatment for Participants

Name: _____DOB: _____Phone:_____

Address: _____

In the event emergency medical aid/treatment is required due to illness or injury while being on the property of the agency, I authorize the staff of Maryland Therapeutic Riding, Inc. to:

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

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Physician's Name: ____ _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to medications: _____

I am taking the current medications: _____

I have the following ongoing medical condition(s): _____

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 person(s) above is unable to be reached.

Signature: _____ Date: _____
(Participant, Parent or 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 being on the property of the agency.
□ Parent or legal guardian will remain on site at all times while volunteering
□ In the event emergency treatment/aid is required, I wish the following procedure to take place:
_____
_____
_____

Signature: _____Date: _____
(Participant, Parent or Legal Guardian)

Participant's Consent for Release of Information

I hereby authorize: _____
(Person or facility)

to release information from the records of: _____ DOB: _____
(Participant's name)

The information is to be released to: *Maryland Therapeutic Riding, Inc. (Operating Center)*

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- ❑ Medical History
- ❑ Physical Therapy evaluation, assessment and program plan
- ❑ Occupational Therapy evaluation, assessment and program plan
- ❑ Speech Therapy evaluation, assessment and program plan
- ❑ Mental Health diagnosis and treatment plan
- ❑ Individual Habilitation Plan (I.H.P.)
- ❑ Classroom Individual Education Plan (I.E.P.)
- ❑ Psychosocial evaluation, assessment and program plan
- ❑ Cognitive-Behavioral Management Plan
- ❑ Other: _____

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to: _____

_____

_____

_____

Release of Liability

Name of Participant_____

I recognize that horseback riding, assisting in riding lessons, caring for, and being in the near vicinity of, horses are high risk activities.

I hereby agree that my involvement in such activities and/or my presence on MTR premises is at my own risk.

I hereby release MTR, its officers, employees, volunteers and agents from any and all liability arising out of my participation in such activities and/or my presence on MTR premises (including costs and attorneys fees) regardless of whether or not liability is premised on negligent actions or omissions of such released parties or otherwise.

I hereby agree to indemnify and hold harmless MTR, its officers, employees, volunteers and agents from any and all suits, actions, claims of any type arising out of my involvement in such activities and/or my presence on MTR premises whether or not such suits, etc. are premised on negligent actions or omissions of such indemnified parties or otherwise.

I have read this agreement and fully understand its contents.

PLEASE SIGN HERE: _____

_____
Date