Flying Free Therapeutic Riding Center, Inc.

Kirsten Robbie, CEO
P.O. Box 63
Woodstock, CT 06281
(959) 255-3405
Flyingfreetrc@gmail.com

Participant's Application & Health History

General Information

Participant:

____

D.O.B.:_______________ Age: _____ Height: ______ Weight: ________ Gender: M F

Address:

____

Phone: (H)______________ (Cell)_____________ Email: ______________________________

School / Employer:

____

School/Employer Address:

____

School/ Employer Phone: ____

Parent/Legal Guardian/Caregivers:

____

Address (if different from above):

____

Phone: ____

How did you hear about the program:

____

____

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Health History

Diagnosis: ____Date of Onset: ____________

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognitive			
Allergies			

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MEDICATIONS (include prescriptions, over-the-counter, name, dose, and frequency)

____

____

____

____

____

____

____

Describe 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/ riding)

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PSYCHO/SOCIAL FUNCTION (i.e. work/school including grade completed, leisure interests, relationships/family structure, support systems, companion animals, fears/concerns, etc.)

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

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PHOTO RELEASE

I, ___________________________________ (print name). DO DO NOT

consent to authorize the use and reproduction by Flying Free Therapeutic Riding Center, Inc. of any and all photographs and/or any other audio/visual materials taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature: ____ Date: ______________

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Participant's Medical History & Physician's Statement

Participant: ______________________________ DOB: ______ Height: ______ Weight: _______

Address: ____

Diagnosis: ____ Date of Onset: __________

Past/Prospective Surgeries: ____

Medications:

____

Seizure Type: _____________________________________ Date of Last Seizure: ____________

Are Seizures Controlled? **Y N**

If NO, please explain ____

____

Special Precautions/ Needs:

____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices:

____

For those with Down Syndrome: Altantodens Interval X-rays, Date: __________ Result: + -

**Are signs/symptoms of Atlantoaxial Instability present? Y N **

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognitive			
Allergies			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities or therapies. I understand that the PATH-accredited center, Flying Free Therapeutic Riding Center, Inc., will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Flying Free Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name / Title: ____ MD DO NP PA Other____________

Signature: ____ Date: ____________

Address: ____

Phone: ____________________________ Fax: ________________________ License/UPIN: ______________

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Authorization for Emergency Medical Treatment Form

Participant Staff Volunteer

Name: ________________________________ DOB _________ Phone: _______________

Address: ____

Physician's Name: _______________________ Preferred Medical Facility: ________________

Health Insurance Co.:_____________________ Policy #:______________________________

Allergies to medications: ____

Current medications: ____

In the event of an emergency contact:

Name: __________________________ Relation: _______________ Phone: _______________

Name: __________________________ Relation: _______________ Phone: _______________

Name: __________________________ Relation: _______________ Phone: _______________

Consent Plan

In the event of an 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, and the above cannot be reached, I authorized Flying Free Therapeutic Riding Center, Inc. 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 x-rays, surgery, hospitalization, medication, and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person(s) above cannot be reached.

Date: _____________ Consent Signature: ____

Client, Parent, or Legal Guardian

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Non-Consent Plan
I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency.

- ☐ Parent or legal guardian will remain on site at all times during equine-assisted activities.
- ☐ In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

____

Date: ____________ Non-Consent Signature: ____

Client, Parent, or Legal Guardian

Liability Release: ___________________________________ (name) would like to participate in Flying Free Therapeutic Riding Center, Inc. I acknowledge the risk and potential risks of horseback riding and related equine activities, including serious bodily harm. However, I feel that the possible benefits to myself / my child / my ward are greater than the risk assumed. I hereby, intending to be legally bound for myself, my heirs, and assigns, executors, and administrators, waive and release forever all claims for damages against Flying Free Therapeutic Riding Center, Inc., its Directors, Instructors, Therapists, Aides, Volunteers, and/or Employees for any and all injuries and /or losses I/my child/my ward may sustain while participating in the program from whatever cause including but not limited to the negligence of these released parties.

The undersigned acknowledges that he/she has read this form in its entirety, that he/she understands the terms of this release and has signed this release voluntarily and with full knowledge of the effects thereof.

Date: __________ Signature: ____

Client, Parent, or Legal Guardian