



A H O R S E C O N N E C T I O N

REGISTRATION PACKET

Date: _____

Client: _____ Date of Birth: _____ Age: _____

Address: _____

Parents or Guardian: _____

Address: _____

Daytime Phone (HOME/WORK): _____ Evening Phone (HOME/WORK): _____

Mobile or Pager Number: _____

Email Address: _____

School or Facility presently attending: _____

In case of emergency contact: _____ Phone: _____

Or Contact: _____ Phone: _____

Have you or your child ever been around or on a horse or pony? Please describe when, where, response.

Please provide any scheduling information you have that will help us meet your needs, ie: Preferred Days/Times/Hours of school/Hours of work:

Please use the space to provide any additional information or experience you would like to provide that will help the equine assisted therapy team best serve you/your child's needs:



A H O R S E C O N N E C T I O N

If services are for your child, does your child have siblings? If so, have they ever been around or on a horse/pony? Please describe.

Medication (include prescription, over-the-counter, name, dose and frequency):

Describe participant's abilities/difficulties in the following areas (include assistance required or equipment needed).

PHYSICAL FUNCTION (ie Mobility skills such as transfers, walking, wheelchair use, driving):

PSYCHOSOCIAL FUNCTION (ie Work/school, leisure interests, support systems, family relationships, companion animals, fears/concerns/aspirations, etc):

COMMUNICATION FUNCTION (ie verbal, non-verbal, gestural, picture/symbols - Methods used for current communication, etc.):

GOALS (ie Why did you apply for participation? What would you like to accomplish?):

Thank you for taking the time to fill out this information that will be helpful in best serving your needs!



A H O R S E C O N N E C T I O N

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Yes or No	Comments
Vision		
Hearing		
Sensation		
Communication		
Heart		
Breathing		
Digestion		
Elimination		
Circulation		
Emotional		
Behavioral		
Pain		
Bone/joint		
Muscular		
Thinking/cognition		
Allergies		



A HORSE CONNECTION

PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____ (Facility/Person)

To release information from the records of: _____ (Participant Name) whose Date of Birth is: _____.

The information is to be released to: Nancy King, OTR/L for the purpose of developing an Occupational Therapy Program for the above named participant. The information to be released is marked below:

- ____ Medical History
- ____ Occupational Therapy evaluation, assessment and program plan
- ____ Speech Therapy evaluation, assessment and program plan
- ____ Physical Therapy evaluation, assessment and program plan
- ____ Classroom Individual Education Plan (I.E.P.)
- ____ Psychosocial Evaluation, assessment and program plan
- ____ Cognitive-Behavioral Management Plan

Other: _____

A HORSE CONNECTION agrees to maintain all information received in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Date: _____ **Signature:** _____ (Participant, Parent or Legal Guardian)

Please send materials to:
 Nancy King
 A HORSE CONNECTION
 PO Box 473
 Saugerties, NY 12477 • (845) 417-4646



A H O R S E C O N N E C T I O N
LIABILITY RELEASE FORM

_____ (Client's Name) would like to participate in the Equine Assisted Therapy Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against A HORSE CONNECTION, Nancy King, OTR/L/King Management, Inc./The Southlands Foundation, each organization's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and or losses I/my son/my daughter/my ward may sustain while participating in the Equine Assisted Therapy Program.

Signature: _____ (Client, Parent or Guardian)

Date: _____



A H O R S E C O N N E C T I O N

**CONSENT TO PHOTOGRAPH, TAKE MOTION PICTURES,
VIDEO TAPE, SOUND RECORD AND/OR TELEVISION**

Parent/Guardian/Client

I hereby give A HORSE CONNECTION and Nancy King the right to photograph, televise, film, video tape and/or sound record the acts, appearances and utterances of _____ (Client Name) and to use any descriptive words or names, including the name of _____ (Client Name) in connection therewith and without limit as to time, to produce and reproduce the same or any part thereof by any method and to use said photographs, films, video tapes and/or sound recordings for any purpose which A HORSE CONNECTION and Nancy King deems proper in the interest of newspapers, television media, brochures, pamphlets, instructional material, books and clinical material, medical education, knowledge and/or research. All such photographs, films and/or sound recordings shall be the exclusive property of A HORSE CONNECTION and Nancy King and I hereby relinquish all right, title and interest therein.

With respect to the foregoing, no inducements or promises have been made to me to secure my signature to this release other than the intention of A HORSE CONNECTION and Nancy King to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding A HORSE CONNECTION and Nancy King and it's work.

Signature: _____ (Client, Parent or Guardian)

Date: _____



A H O R S E C O N N E C T I O N

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Participant's Name: _____ Date of Birth: _____ Age: _____

Address: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Co.: _____ Policy No.: _____

Allergies to medications? _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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, and the above cannot be reach, I authorize Nancy King, OTR/L to:

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

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 above is unable to be reached.

Date: _____

Consent Signature : _____ (Client, Parent or Legal Guardian)

MUST BE SIGNED IN THE PRESENCE OF OPERATING CENTER STAFF



A H O R S E C O N N E C T I O N

Date: _____

Dear Physician:

Your patient, (participant's name)_____ is

____ Interested in participating in hippotherapy

____ Interested in continuing to participating in hippotherapy

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to hippotherapy. 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/Myositis 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

OTHER

- Age - under 4 year
- Indwelling Catheters
- Medications - i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

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
- Peripheral Vascular Disease
- 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 hippotherapy, please feel free to contact the operating center at the address and phone number indicated above.

Sincerely,

Nancy King, MS, OTR/L



A H O R S E C O N N E C T I O N

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled?: Yes No Date of last seizure: _____

Shunt present?: Yes No Date of last revision(s): _____ Date of last Tetanus Shot: _____

Special Precautions/Needs: _____

Mobility: Independent Amulation? Yes No Assisted Ambulation? Yes No Wheelchair? Yes No

Braces/Assistive Devices: _____

Please indicate current or past difficulties 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 equestrian activities. However, I understand that the therapeutic riding 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, Speech Language Pathologist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Phone: (____) _____ License/UPIN Number: _____