



## Participant's Application & Health History

### GENERAL INFORMATION

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Caregivers: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### 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			

**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?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHOTO RELEASE**

- I  DO
- DO NOT

consent to and authorize the use and reproduction by \_\_\_\_\_  
(center)

of any and all photographs and 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: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of center staff*



## Authorization for Emergency Medical Treatment Form

Participant Name: \_\_\_\_\_ DOB \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

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,

I authorize **Turning Point Ranch Therapeutic Riding Center** 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.

### 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(s) above is unable to be reached.

Date: \_\_\_\_\_ Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in presence of center staff*

### Non-Consent Plan

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

In the event emergency treatment/aid is required, I wish the following procedure to take place:

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Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in presence of center staff*

Spring 2012

(Completed by Physician)



## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_

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: AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + —

Neurologic Symptoms of Atlanto Axial Instability: \_\_\_\_\_

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

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

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 NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_



## Rider Liability Release Form

**Release of Liability:** \_\_\_\_\_, would like to participate in the Turning Point Ranch Therapeutic Horseback Riding program.

By my signature below, I (or parent/caregiver/guardian for participants under 18) acknowledge that I am aware of the risks and potential risks of riding and involvement with horses.

I hereby, intending to be legally bound for myself, my heirs, and assigns, executors or administrators do waive and release forever all claims of damages against Turning Point Ranch, its Board of Directors, Instructors, Therapists, Aides, Volunteers, landowners, and employees from any and all liability and claims of any nature whatsoever, *including taking action to control, restrain or confine the undersigned for the safety and protection of the undersigned or others* and any damages whatsoever (including costs, expenses and attorney's fees) that might result from damages, injuries, or losses to their person or property during or in connection with, or arising out of any class, lesson, demonstration, show, clinic, event or other function.

I understand that under Oklahoma Law, an equine activity sponsor or professional shall not be liable for any injury to or the death of a participant or equine in equine activities resulting from the inherent risks of equine activities.

In exchange for the use of property under the control of Turning Point and other valuable consideration, I agree that my use of the premises and any animals, property or equipment under the control of Turning Point is at my own risk. I agree to indemnify and hold harmless Turning Point, its officers, members, employees, volunteers and agents from any and all suits, actions or claims of any type arising from my use of the premises or equipment or participation in an equine activity or of such use or participation by a guest of mine whether or not such claims result directly from the negligent act or omissions of the indemnified parties or otherwise.

I further acknowledge that I have read this agreement and fully understand its content.

AGREED: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of adult rider or parent/guardian/caretaker or minor rider

