



Horsin' Around



A non-profit therapeutic riding program

1032 John Carter Road Bloomingdale, GA 31302 912-748-7917

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

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			

(over)

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 _____
(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



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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 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 _____ to:

(Center's Name)

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 procedures to take place:

Date: _____ Consent Signature: _____

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

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

**CLARK'S RIDING LESSONS & TRAIL RIDES, INC.
HORSIN ' AROUND, INC.**

1032 JOHN CARTER ROAD BLOOMINGDALE, GA 31302

RELEASE OF LIABILITY & HOLD HARMLESS AGREEMENT

ACKNOWLEDGEMENT OF RISK & ACCEPTANCE OF RESPONSIBILITY

I recognize that there is a significant element of risk in any adventure, sport or activity associated with the outdoors. Knowing of the inherent risk, danger and rights involved in the activities, I certify that myself and my family, including any minor children, are fully capable of participating in the activities.

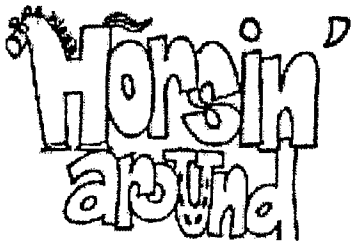
I assume full responsibility for my family, visitors, invitees and myself, including any minor children, for bodily injury, death, loss of personal property and expenses thereof.

This is a release, hold harmless and indemnification of the undersigned in favor of Judith A. Clark, Gary L. Clark for Clark's Riding Lessons & Trail Rides, Inc. and Horsin' Around, Inc. and/or their agents, family and employees shall constitute the best evidence of my agreement of offered as evidence in any court proceeding.

I, _____
have read and understand fully the agreement above.

Signature _____

Date _____



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1032 John Carter Road Bloomingdale, GA 31302 912-748-7917

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

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 years
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 Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
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 equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Judith A. Clark
President

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 AtlantoAxial 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			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the NARHA 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: _____

HORSIN' AROUND, INC.
CLARK'S RIDING LESSONS AND TRAIL RIDES, INC.
RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT

ACKNOWLEDGEMENT OF RISK
AND
ACCEPTANCE OF RESPONSIBILITY

DATE: _____

WARNING!
**UNDER GEORGIA LAW AN EQUINE ACTIVITY SPONSOR OR
EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO
OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES
RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES,
PURSUANT TO CHAPTER 12 OF TITLE 4
OF THE OFFICIAL CODE OF GEORGIA.**

The undersigned(s) recognizes that there is a significant element of risk in any adventure, sport or activity associated with the outdoors, including equine activities. Knowing of the inherent risk, danger and rights involved in such activities, I certify that myself, my family, and including any minor children ("Releasers") are fully capable of participating in the activities.

Therefore, for and in consideration of the sum of One Dollar (\$1.00) and other good and valuable consideration, including use of the equipment and participation in the programs, facilities, and/or services offered by or through Clark's Riding Lessons and Trail Rides, Inc. ("Clark's Riding") and Horsin' Around, Inc. ("Horsin' Around") (Clark's Riding and Horsin' Around being hereafter collectively referred to as "Clark's/Horsin'"), the receipt and sufficiency of which are hereby acknowledged, the undersigned(s) hereby expressly agrees that the Releasers' use of equipment and participation in the programs, facilities and services offered by Clark's/Horsin' shall be undertaken at the Releasers' sole risk. The undersigned(s) hereby represents that all Releasers are physically

able to participate in the programs, facilities and services offered by or through Clark's/Horsin' and the use of any of its equipment, facilities and/or services. On behalf of all Releasers and their heirs, successors, assigns, and family members, the undersigned(s) hereby expressly agrees that Gary L. Clark, Judith A. Clark, Clark's/Horsin' (Gary L. Clark, Judith A. Clark, and Clark's/Horsin' being hereafter collectively referred to as the "Clark Parties"), and private landowners whose land is used by Clark's/Horsin' for lessons or trail riding (hereafter the "Private Landowners") shall not be liable to the Releasers and their heirs, successors, assigns and family members for any claims, demands, injuries, damages, actions, causes of action, or liabilities whatsoever arising out of, or connected with Clark's/Horsin' and/or the use by any of the Releasers of Clark's/Horsin's equipment, facilities, services, and/or programs. The undersigned(s), on behalf of herself and all Releasers, and their respective heirs, assigns, and family members, hereby expressly releases and discharges the Clark Parties and Private Landowners, and their respective officers, employees, directors, agents, volunteers, instructors, staff, shareholders, heirs, successors, administrators, and assigns (collectively the "Releasees") from any and all liabilities for such claims, demands, injuries, damages, actions, causes of action, or liabilities, including liabilities for any and all acts of active or passive negligence.

Releasers, including the undersigned(s), shall indemnify and hold harmless the Releasees and their respective directors, officers, employees, agents, volunteers, instructors, staff, shareholders, heirs, successors, administrators and assigns from and against any and all claims, demands, injuries, actions, causes of action, attorneys' fees, and expenses of whatever kind and nature, arising out of or in connection with participation by Releasers in the services and programs, or use by Releasers of any of the equipment, facilities or premises provided by or through Clark's/Horsin', or which are otherwise released herein.

By the execution of this document, the undersigned(s) assumes full responsibility for his/her family, visitors, invitees, and himself/herself, including any minor children, for bodily injury, death, and loss of personal property and expenses thereof.

This is a release, hold harmless and indemnification of the undersigned and all Releasers in favor of all Releasees and shall constitute the best evidence of my agreement if offered as evidence in any court proceedings.

I/we represent that I/we are all of the parent(s) or legal guardian(s) of the minor children listed below, and that I/we have read, understand and fully agree to the terms of this Agreement.

PLEASE PRINT NAME(S) OF MINOR CHILDREN PARTICIPATING IN ACTIVITIES:

HELMET:

Offered: _____
Used: _____
Refused: _____

Signature: _____ L.S.

Address: _____

Telephone: _____

Signature: _____ L.S.

Address: _____

Telephone: _____