EQUIGRACE

2017 Equestrian Registration

Participant Name _____

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

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____Alternative #: _____

How did you hear about the program? _____

I am Interested in:

___ Therapeutic Riding ___Therapeutic Groundwork ___ Therapeutic Horsemanship

___ Senior Programs ___ Veterans/Heroes Services ___ Integrated Volunteering

Lesson Format:

___ Private ___ Group

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

_____

_____

STUDENTS INTERESTS AND HOBBIES

_____

_____

Additional Information that may assist us in making this a great experience

_____

_____

_____

Signature: _____ Date: _____

(participant/parent/legal guardian)

EquiGrace, Inc.
PO Box 268 ~ Shawnee, CO 80475
303-838-7122 ~ equigrace@gmail.com ~ www.equigrace.com

EQUIGRACE

Authorization for Emergency Medical Treatment

Preferred Emergency Facility _____
Allergies _____
Current Medications (include prescription, over the counter and dosage)
_____
Medical Conditions _____
In the event of an emergency, contact
Name _____Phone _____ Relation _____
Name _____Phone _____ Relation _____

Consent Plan
In the event of an emergency medical aide/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 EquiGrace to

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

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician.

Consent Signature _____ Date _____
(participant/parent/legal guardian)

Non-Consent Plan
I do NOT give my consent for emergency medical treatment/aide 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 activities. In the event emergency treatment/aid is required, I wish the following procedures to take place_____
_____
Non-Consent Signature _____ Date _____
(participant/parent/legal guardian)
Witness Signature _____Name _____

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Participant's Medical History & Physician's Statement

(In order to safely provide service, this two page form is to be completed by your Physician.
No one will be permitted to participate without a physician's signature)

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
Past/Prospective Surgeries: _____
Medications: _____
Tetanus Shot Y N Date _____
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:
Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent _____ Cervical AAI X-ray Date
A mandatory physicians letter stating results for AII are negative MUST be received prior to an initial evaluation and admission to EquiGrace, Inc.

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

Please indicate any special precautions: _____

_____

_____

_____

_____

_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications and will conduct an evaluation of abilities/limitations in performing exercises/activities and implementing an appropriate equestrian program. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____

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

Coxarthrosis

Animal Abuse

Physical/Sexual/Emotional Abuse

Active Hallucinations
Dangerous to Self or Others

Pathologic Fractures

Joint subluxation/dislocation

Cranial Defects

Cardiac Condition

Heterotopic Ossification/Myositis Ossificans

Blood Pressure Control

Osteoporosis

Exacerbations of Medical Conditions (e.g., RA, MS)

Spinal Joint Fusion/Fixation Fire Setting

Spinal Joint Instability/Abnormalities Hemophilia

Medical Instability

Scoliosis 30 degrees or greater

Neurologic

Migraines

Hydrocephalus/Shunt PVD

Seizure Respiratory Compromise

Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Recent Surgeries

Substance Abuse

Spinal Cord Injury (contraindication if injury is above T-6)

Other

Thought Control Disorders

Age - under 4 years

Hemophelia

Indwelling Catheters/Medical Equipment

Medications - e.g., 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 EquiGrace, Inc. at 303-838-7122, email at equigrace@gmail.com or PO Box 268, Shawnee, CO 80475

EQUIGRACE

Equestrian Release Agreement

I, the undersigned, as an adult rider 18 or older, or as the parent and/or legal guardian of (please print name) _____, for and in consideration of the agreement of EquiGrace, Inc. to provide riding and equine assisted activities instruction to said undersigned or minor, does/do hereby forever release, acquit, discharge and hold harmless EquiGrace, Inc., its officers, trustees, agents, employees, representatives, successors, and Whispering Pines Ranch, its officers, trustees, agents, employees, representatives, successors, and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned and/or said minor may now, or in the future, have against EquiGrace, Inc., its officers, trustees, agents, employees, representatives, successors, and Whispering Pines Ranch, its officers, trustees, agents, employees, representatives, successors, and assigns on account of any personal injuries, physical or mental condition, known or unknown to the person of said undersigned and/or minor and the treatment therefore as a result of, or in any way growing out of, the acts of EquiGrace Inc., its officers, trustees, agents, employees, representatives, successors , and Whispering Pines Ranch its officers, trustees, agents, employees, representatives, successors, and assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

WARNING - Under Colorado Law, an 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 section 13-21-119, Colorado Revised Statutes.

Signed:_____ Date _____
(participant/parent/legal guardian)

Witnessed:_____ Date _____

Photo Release
___ **I Do** ___ **I Do not**
Consent to and authorize the use and reproduction by EquiGrace, Inc. of any and all photographs and any other audio/visual materials taken of me/the client, for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Internet Release
___ **I Do** ___ **I Do not**
Consent to and authorize the use and reproduction by EquiGrace, Inc. of any and all photographs and any other audio/visual materials taken of me/the client, for use on EquiGrace, Inc. website or Facebook page, for promotional material, educational activities, exhibitions or for any other use for the benefit of the program on the internet.

Signed:_____ Date _____
(participant/parent/legal guardian)

Witnessed:_____ Date _____

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