



Rider's Application and Health History

GENERAL INFORMATION

Rider: _____

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

Address: _____

Home Phone: _____ E-mail: _____ Alternative #: _____

Employer/School: _____ Phone #: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

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 (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?) _____

LIABILITY RELEASE

_____ (Rider's Name) would like to participate in the Grace Lake Ministries Horsemanship Program. I acknowledge the risks and potential risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks 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 Grace Lake Ministries, its Board of Directors, Instructors, Therapists, Aids, Horse Owners Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Grace Lake Ministries Horsemanship programs.

WARNING – Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a rider in equine activities resulting from the inherent risks of equine activities.

Signature: _____
Rider, Parent, Legal Guardian

Date: _____

PHOTO RELEASE

I DO
 DO NOT

Consent to and authorize the use and reproduction by Grace Lake Ministries 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: _____
Rider, Parent, Legal Guardian

Date: _____



Grace Lake Ministries

Date: _____

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete 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 the attached form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
MS)
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/
Tethered Cord/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA,

Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

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 the center at the address/phone indicated below.

Sincerely,
Holly Robinson, LSW
Executive Director

Grace Lake Ministries, Inc.

9611 FM 1827 Anna, TX 75409

(972) 837-4621



RIDER'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Rider: _____ 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: _____ Results + --

Neurological 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 equine activities. However, I understand that Grace Lake will weigh the medical information above against the existing precautions and contraindications.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: () _____ License/UPIN Number: _____

Authorization for Emergency Medical Treatment Form

Name: _____ Rider _____ Staff _____ Volunteer _____
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 an agency, I authorize Grace Lake Ministries 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

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness of injury during the process of receiving services 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 procedures to take place:

Date: _____ Consent Signature: _____
Client, Parent, or Legal Guardian