



**Savannah Station TRP**  
PO Box 851215  
Yukon, OK 73085  
(405) 651-2324  
Email: savannahstationtrp@gmail.com

## Liability Release

\_\_\_\_\_ (Client's Name) would like to participate in the Savannah Station Therapeutic Riding Program. Under Oklahoma 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. 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 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 Savannah Station Therapeutic Riding Program, it's Board of Directors, Instructors, Therapists, Aides, Center Property Owner (Redlands Community College, Glenn Farm, Reed Farm, Kennard Farm), Volunteers and / or Employees for any and all injuries and/or losses I /my son /my daughter /my ward may sustain while participating in Savannah Station Therapeutic Riding Program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Client, Parent, or Guardian



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**Authorization for Emergency Medical Treatment Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ CELL Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Allergies to medications: \_\_\_\_\_  
Current medications: \_\_\_\_\_

In the event of an emergency, contact: [If primary contact is by cell phone, please provide cell phone #]  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent Plan**

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 Savannah Station TRP administrators 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.

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 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 assisted activities

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

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

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_  
Client, Parent or Legal Guardian



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## Participant's Consent for Release of Information

I hereby authorize: \_\_\_\_\_

*(person or facility)*

to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_

*(participant's name)*

The information is to be released to: Savannah Station Therapeutic Riding Program,  
Dr. Velinda Baker, Director

*(center or therapist's name)*

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Mental Health diagnosis and treatment plan
- Individual Habilitation Plan (I.H.P.)
- Classroom Individual Education Plan (I.E.P.)
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral Management Plan
- Other:

\_\_\_\_\_

This release is valid for **one year** and can be revoked, in writing, at my request.

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

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to:

Dr. Velinda Baker, Director  
PO Box 851215  
Yukon, OK 73085  
405-651-2324



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**Participant's Application and Health History by Guardian**

Participant: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Gender: M F  
 Address: \_\_\_\_\_ Town: \_\_\_\_\_  
**Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_**  
 Employer/School: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent/Legal Guardian: \_\_\_\_\_  
 Address (if different than 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:*

Area	Y	N	Comments
Vision			
Hearing			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

(see next page)

**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 the program? What would you like to accomplish?)

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

**PHOTO RELEASE**

I  DO  
 DO NOT

consent to and authorize the use and reproduction by \_\_\_\_\_ Savannah Station TRP \_\_\_\_\_ 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)

**SHIRT SIZE**

My child's T-Shirt size is:

Child's: XS S M L XL                      Adults: XS S M L XL XX



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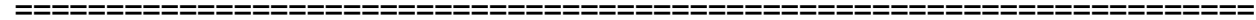
**Medical History and Physician's Statement Form**

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 Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

- Poor Endurance
- Skin Breakdown

**Neurologic**

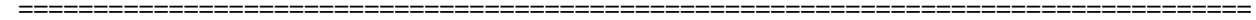
- Hydrocephalus/Shunt
- Seizure
- Spina Bifida/Chiari II malformation/
- Tethered Cord/Hydromyelia

**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, MS)
- Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

**Other**

- Age - under 4 years
- Indwelling Catheters/Medical Equipment
- Medications - i.e. photosensitivity



Thank you very much for your assistance. If you have any questions regarding this patient's participation in equine assisted activities, please feel free to contact the director at the address/phone indicated below.

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**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:**

Area	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			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH Intl center will weigh the medical information given against the existing precautions and contraindications. 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: \_\_\_\_\_

