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
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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

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, MS)
Fire Settings
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 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: _____