Hero Hearts EquiCenter, Inc.

8876 E. Hawthorn Lane • Hereford, AZ 85615

Participant Application Form

Please fill out all 7 pages of this application and return to Hero Hearts.

New Applicant? ☐ Yes ☐ No

PARTICIPANT NAME:_____ AGE:_____

ADDRESS:_____ CITY_____

STATE:_____ ZIP:_____ HOME PHONE: ( )_____

ALTERNATE PHONE: ( ) _____ EMAIL:_____

DATE OF BIRTH:_____/_____/_____ HEIGHT:_____ WEIGHT:_____

PARENT/GUARDIAN (if under 18 years):_____

DISABILITY:_____ DATE OF ONSET:_____/_____/_____

PLACE OF EMPLOYMENT:	**Business Phone & Hours:**
Father/Husband Name & Employer:	**Business Phone & Hours:**
Mother/Wife Name & Employer:	**Business Phone & Hours:**

PHYSICIAN NAME:_____

ADDRES:_____

CITY/STATE_____ ZIP:_____ PHONE: ( )_____

****

Parent/Guardian must complete this form before any minor participant can be accepted. If the participant is of legal age and mentally competent, he/she may complete the form. Every effort will be made to ensure safety and avoid any accident. NO LIABILITY can be accepted by any of the organization's trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the lessons are conducted.

I_____would like to participate in Hero Hearts EquiCenter, Inc. I have discussed this with my (or the child's) doctor. Futhermore, I grant permission to a Hero Hearts instructor or therapist to contact my doctor or therapist for further clarification of medical information if needed (this information will be treated with confidentiality). I understand that NO LIABILITY can be accepted by any of the organizations concerned with this instruction or therapy, including Hero Hearts EquiCenter, Inc. I understand that the final decision regarding acceptance, selected therapeutic activities, and continued participation rests with the Hero Hearts staff, upon due consideration of the individual's special needs and the safety of the participant, staff, volunteers and horses.

SIGNATURE OF PARTICIPANT OF LEGAL AGE:_____DATE:_____/_____/_____

SIGNATURE OF PARENT(S)/GUARDIAN:_____DATE:_____/_____/_____

****

(Office Use ONLY) Date Application Received:_____/_____/_____ Approved_____

(Program Director)

Hero Hearts EquiCenter, Inc.

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

NAME:_____ DATE OF BIRTH:_____/_____/_____

ADDRESS:_____

CITY/STATE:_____ZIP:_____ PHONE :( )_____

PHYSICIAN'S NAME:_____ PHONE: ( )_____

HEALTH INSURANCE COMPANY:_____ POLICY#:_____

ALLERGIES TO MEDICATIONS: ___YES ___NO IF YES, PLEASE LIST:_____
_____

CURRENT MEDICATIONS:_____

In the event of an emergency, please contact:

NAME:_____RELATION:_____PHONE: ( )_____

NAME:_____RELATION:_____PHONE: ( )_____

NAME:_____RELATION:_____PHONE: ( )_____

In the event of an emergency and medical aid/treatment is required due to illness or injury during the process of receiving services or while on Hero Hearts EquiCenter, Inc. premises, I authorize Hero Hearts to secure and retain medical treatment and transportation if needed and 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. Emergency services from this area utilize Sierra Vista Regional Health Center or Copper Queen Hospital. Other preference:_____

Date:_____/_____/_____ Signature:_____
(Participant, or parent/legal guardian if participant under 18 years)

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 on the Hero Hearts EquiCenter, Inc. premises.

☐ 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:_____/_____/_____ Signature:_____
(Participant, or parent/legal guardian if participant under 18 years)

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MEDICAL HISTORY/PHYSICIAN'S RELEASE

HEIGHT:_____ WEIGHT:_____ DIAGNOSIS:_____
DATE OF ONSET:_____/_____/_____ Tetanus shot: ___Yes ____No Date Given:_____/_____/_____

Seizures? ____Yes _____No If Yes, Type:_____ Controlled?_____
Date of last seizure:_____/_____/_____

Medications:_____

Areas	Normal	Problems/Deficits	Comments/Surgeries
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Orthopedic			
Scoliosis			
type/degree			
Allergies			
Learning Disability			
Mental Impairment			
Psych Impairment			
Shunt	Yes:	No:	
GI Tubes	Yes:	No:	
Catheter	Yes:	No:	
Other			

Mobility	Independent Ambulation	_____Yes	_____No
	Braces	_____Yes	_____No
	Crutches	_____Yes	_____No
	Wheelchair	_____Yes	_____No

Other special precautions:_____
I have reviewed the Contraindications supplied with this application. In my opinion this patient has none of these contraindications and may participate in supervised equestrian activities. I understand that the final decision regarding acceptance rests with the Hero Hearts EquiCenter, Inc. staff, upon due consideration of the participant's special needs, precautions and contraindications, and the safety of the participant, staff, volunteers, and horses. **This form must be signed and stamped by a physician.**

PHYSICIAN'S NAME: (please print):_____

PHYSICIAN'S SIGNATURE:_____

ADDRESS:_____PHONE:_____

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PARTICIPANT NAME (please print):_____

PARTICIPANT RELEASE

Known by all present:

The undersigned understands and agrees that there is inherent risk of injury in all equine-related activities, both mounted and non-mounted. It is understood that horses may stumble, bite, run, kick, or make unpredictable movements which may cause a participant to be injured by or fall from the horse. I am willing and able to accept full responsibility for my own safety and welfare, and that of my child or ward.

The horseback riding sessions in particular will focus on acquisition of riding skills as well as therapeutic benefits to the individual participants. As part of typical skill development, the instructor may progress the rider from two side walkers to one side walker, to no side walker and eventually to independent riding if the instructor decides that it is appropriate for the rider's ability.

I have been advised and I understand that the utmost attention will be given to the safety of the rider. I am also fully aware that the risk of a fall from the horse is greater as the rider's independence increases. Knowing the potential of increased risk, I agree and support the participation of the above named in therapeutic horseback riding.

I do hereby release and discharge Hero Hearts EquiCenter, Inc., its instructors, staff, volunteers and horse owners from any and all responsibility or liability to me or my child in connection with any injuries suffered by me as a result of my activity/participation involving Hero Hearts EquiCenter, Inc. horses/ponies, and property.

Dated this_____day of_____20_____

Signature (parent, guardian, adult rider):_____

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PARTICIPANT NAME (please print):_____

PHOTO RELEASE

For valuable consideration given and which is hereby acknowledged, the undersigned hereby **grants**:_____ or **does not grant**:_____ Hero Hearts EquiCenter, Inc. permission to take or have taken still and moving photographs and films including television pictures of the above named participant and **consents**:_____ or **does not consent**:_____ and authorizes Hero Hearts EquiCenter, Inc. , its advertising agencies, news media, and any other persons interested in this organization and its work, to use and reproduce the photographs, films and pictures and to circulate and publicize the same by all means including without limiting the generality of the foregoing - newspapers, television media, brochure, pamphlets, instructional material, books and clinical material.

With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of Hero Hearts EquiCenter, Inc. to use or cause to be used such photographs, films and pictures for the primary purpose of promoting and aiding Hero Hearts EquiCenter, Inc. and its work.

Dated this _____ Day of_____, 20_____.

Signature (parent, guardian, adult rider):_____

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Contraindications

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
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossifications
Joint subluxation/dislocation
Osteoperosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/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 or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone number listed above.

Sincerely,