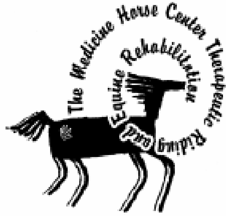

The Medicine Horse Center
Equine Assisted Therapies
P.O. Box 1074, Mancos, CO 81328
Tel: 970-533-7403 Fax: 970-533-7405

Instructions for Equine Experiential Learning Application

The following forms are to be filled out by the following persons:

Page 1 – Instructions

Page 2 – Client or Parent/Guardian

Page 3 – Client or Parent/Guardian

Page 4 – Client or Parent/Guardian

Page 5 – Client or Parent/Guardian

Page 6 – Client or Parent/Guardian

Page 7 – Client or Parent/Guardian

All forms must be completed in their entirety and submitted to the Medicine Horse Center prior to the first session.

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Participant's Registration and Release Form

Client:_________________________________Date of Birth:_____________ Weight:_____lbs

For the safety of our horses, there is a **client weight restriction of 180 lbs.**

Street:__________________________________City:_______________State:_____Zip:________

Phone: Home:____________________Work ____________________Emergency:____________

Parent/Guardian Name:____

Address/Phone:____

School or institution presently attending:_______________________________________

In case of emergency contact:______________________________Phone:___________________

contact:______________________________Phone:___________________

Photo Release

I hereby consent to and authorize the use and reproduction by The Medicine Horse Center of any and all photographs and any other audiovisual materials taken of me/my child/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Signature:____ Date:____________

(Participant or Parent/Guardian)

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Participant Liability Release Agreement

I, ______________________(Client's Name) would like to participate in The Medicine Horse Center's Equine Assisted Therapy Programs. I acknowledge the risks and potential for risks of being around horses. However, I feel that the possible benefits to myself/ my child/ 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 The Medicine Horse Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my child/my ward may sustain while participating in The Medicine Horse Center's Therapeutic Riding and Equine Rehabilitation Program.

UNDER COLORADO LAW, AN EQUINE ACTIVITY SPONSOR IS NOT LAIBLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERANT RISKS OF EQUINE ACTIVITIES THAT ARE OBVIOUS AND NECESSARY, PURSUANT TO 13-21-119 COLORADO REVISED STATUES.

Signature:____ Date:____________

(Participant or Parent/Guardian)

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Participant's Authorization for Emergency Medical Treatment

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 ***The Medicine Horse Center*** to:

_X_ Secure and retain medical treatment and transportation if needed.

_X_ Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment at my expense.

I hold the Medicine Horse Center harmless for any expenses incurred in my interests.

Name:____ Phone:_____________________

Address:____

Emergency Contact: ___________________________________ Phone: _____________________

Physician's Name and Phone:____

Preferred Medical Facility: ____

Health Insurance Co.: _________________________________ Phone: ______________________

Policy #: ________________________________ Group #: ______________________________

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 below is unable to be reached.

Print Name: ____ Phone: _______________________

Address:____

Consent Signature:____ Date: ______________

(Participant or Parent/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. In the event emergency treatment/aid is required, I wish the following procedure to take place:

____

____

____

____

____

Non-Consent Signature:____ Date: __________

(Participant or Parent/Legal Guardian)

Print Name: ____ Phone:____________________

Address:____

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PARTICIPANT HEALTH HISTORY

Health History

Please describe you/your child's current health status, particularly regarding the physical/emotional demands of participating in an equine program. Specify if there are issues with fitness, cardiac, respiratory, bone or joint function, recent hospitalizations or surgeries.

___

___

___

___

Height: ___________________________
Weight: ___________________________

Allergies (Medications, Food, Environmental (e.g. bees, horses, hay, grasses etc…)).

___

___

Current Medications (Any side effects related to behavior, energy level, sun exposure etc…)

___

___

I give my permission for Medicine Horse staff to give allergy medicine (such as Benadryl) to my child, if they are exhibiting signs of an allergic reaction to the horses or the stable environment. Yes___________ No____________

Signature: ___________________________________ Date: ___________

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Therapeutic and Safety Issues

Check and describe applicable issues (indicate current issues, or history of):

___ inattention

___ hyperactivity

___ lack of concentration

___ learning disabilities

___ developmentally delayed

___ mentally challenged

___ boundary issues

___ social skills problems

___ problem with peers

___ separation anxiety

___ anxiety

___ phobias

___ aggressive

___ history of assaulting others

___ manipulative

___ unpredictable or dangerous behavior

___ sensory impairment

___ sensitivity, preferences

___ tics or stereotypic behavior

___ psychosomatic symptoms

___ medical issues

___ self-injurious behavior

___ suicidal ideations

___ history of runaway

___ issues of parental support

___ issues of family support

___ sexual abuse/acting out

___ history of physical abuse

___ history of emotional abuse

___ hallucinations

___ delusions

___ illusions

___ dissociations

___ substance abuse problems

___ legal problems

___ school problems

___ history of animal abuse and/or fire setting

___ seizure disorder

___ possible medication side effects