



## The Medicine Horse Center

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

### Instructions for Therapeutic Riding 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

**Page 8** – Physician or Occupational Therapist

**Page 9** – Physician or Occupational Therapist

**Page 10** – Physician or Occupational Therapist

**Page 11** – Physician or Occupational Therapist

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



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

## 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)



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

**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)



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

## **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:

- Secure and retain medical treatment and transportation if needed.
- 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: \_\_\_\_\_



## The Medicine Horse Center

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

### 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: \_\_\_\_\_



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

**Participant's Consent for Release of Information**

I hereby authorize The Medicine Horse Center for Therapeutic Riding and Equine Rehabilitation to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_

(Participant's Name)

for the purpose of developing a Riding 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: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant or Parent/Guardian)



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

**Physician's Prescription**

Participant's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

***Prescription for Therapeutic Horseback Riding***

Prescription for evaluation and treatment by a Physical, Occupational and/or Speech Therapist, or mental health professional in conjunction with The Medicine Horse Center for Therapeutic Riding and Equine Rehabilitation.

Recommended Frequency: \_\_\_\_\_

Precautions: \_\_\_\_\_

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Print, Type or Stamp**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_



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

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

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

*For Persons with Down Syndrome:*

Negative Cervical X-ray for Atlantoaxial Instability X-Ray Date: \_\_\_\_\_

Negative for clinical symptoms of Atlantoaxial Instability

**Tetanus Shot:** (Circle one) Yes / No **Date:** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Seizure Type** \_\_\_\_\_ **Controlled** \_\_\_\_\_ **Date of Last Seizure:** \_\_\_\_\_

*Please check if patient has a problem or surgeries in any of the following. If yes, please comment.*

Areas	Yes	No	Comment
Allergies			
Auditory			
Cardiac			
Circulatory			
Learning Disability			
Mental Impairment			
Muscular			
Neurological			

Areas	Yes	No	Comment
Orthopedic			
Psychological Impairment			
Pulmonary			
Speech			
Visual			
Other			

**Mobility:** *Independent Ambulation* Y/N *Crutches* Y/N *Braces* Y/N *Wheelchair* Y/N

Please indicate any special precautions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) \_\_\_\_\_

Physician Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Date \_\_\_\_\_

### Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

#### Orthopedic

Spinal Fusion \_\_\_\_\_

Spinal Instabilities \_\_\_\_\_

Atlantoaxial Instabilities \_\_\_\_\_

Scoliosis \_\_\_\_\_

Kyphosis \_\_\_\_\_

#### Medical/Surgical

Allergies \_\_\_\_\_

Cancer \_\_\_\_\_

Poor Endurance \_\_\_\_\_

Recent Surgery \_\_\_\_\_

Diabetes \_\_\_\_\_

**Orthopedic**

- Lordosis \_\_\_\_\_
- Hip Subluxation and Dislocation \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Pathologic Fractures \_\_\_\_\_
- Coxas Athrosis \_\_\_\_\_
- Heterotopic Ossification \_\_\_\_\_
- Osteogenesis Imperfecta \_\_\_\_\_
- Cranial Deficits \_\_\_\_\_
- Spinal Orthoses \_\_\_\_\_
- Internal Orthoses \_\_\_\_\_
- Internal Spinal Stabilization Devices \_\_\_\_\_

**Medical/Surgical**

- Peripheral Vascular Disease \_\_\_\_\_
- Varicose Veins \_\_\_\_\_
- Hemophilia \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Serious Heart Condition \_\_\_\_\_
- Stroke \_\_\_\_\_

**Neurologic**

- Hydrocephalus/shunt \_\_\_\_\_
- Spina Bifida \_\_\_\_\_
- Tethered Cord \_\_\_\_\_
- Chiari II Malformation \_\_\_\_\_
- Hydromyelia \_\_\_\_\_
- Paralysis due to Spinal Cord Injury \_\_\_\_\_
- Seizure Disorders \_\_\_\_\_

**Secondary Concerns**

- Behavior problems \_\_\_\_\_
- Age under two years \_\_\_\_\_
- Age two-four years \_\_\_\_\_
- Acute exacerbation of chronic disorder \_\_\_\_\_
- Indwelling catheter \_\_\_\_\_