Kentucky Foothills Therapeutic Horsemanship Center

7822 HWY 2004

McKee, KY 40447

606-965-2158 kfthc@prtcnet.org [www.kfthc.org](http://www.aftec.us)

No participant may be accepted for therapeutic horsemanship services until all forms have been completed.

If the participant is of legal age and mentally competent, he/she may complete the forms without a parent’s or guardian’s signature.

PARTICIPANT REGISTRATION FORM

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip: \_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Second Phone (if any): ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this program?

PHOTO RELEASE

I DO or DO NOT consent to and authorize the use of and reproduction 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 by and for the benefit of the Kentucky Foothills Therapeutic Horsemanship Center.

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

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

Dear Health Care Provider,

 Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Participant’s Name)

is interested in participating in supervised equine assisted 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 neurological symptomsCoxa Arthrosis Cranial DeficitsHeterotropic Ossification/Myositis OssificansJoint Subluxation/DislocationPathologic FracturesSpinal Joint Fusion/FixationSpinal Joint Instability/Abnormalities**Neurologic**Hydrocephalus/ShuntSeizureSpina Bifida/Chiari II Malformation/ Tethered Cord/ Hydromyelia**Other:**Indwelling Catheter/ Medical EquipmentMedications- ie photosensitivityPoor EnduranceSkin Breakdown | **Medical/Psychological:**AllergiesAnimal AbuseCardiac ConditionPhysical/Sexual/Emotional AbuseBlood Pressure ControlDangerous to Self or OthersExacerbations of Medical Conditions ( ie RA, MS)Fire SettingHemopheliaMedical InstabilityMigrainesPVDRespiratory ConditionsRecent SurgeriesThought Control DisordersWeight Control Disorder |

Thank you for your assistance. If you have any questions or concerns regarding this patient’s participation in Equine Assisted Activities, please feel free to contact us at the center or at the phone/address listed above.

Sincerely,

Cheryl Martin, M.Ed. PATH, Intl. Registered Instructor, KFTHC Program Director

**PHYSICIAN’S STATEMENT**

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Past/Prospective Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizure: Y N 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments: Please indicate current or past special needs in the following systems/areas, including surgeries. |
| Auditory |  |  |  |
| Visual |  |  |  |
| Tactile Sensation |  |  |  |
| Speech |  |  |  |
| Cardiac |  |  |  |
| Circulatory |  |  |  |
| Integumentary/Skin |  |  |  |
| Immunity |  |  |  |
| Pulmonary |  |  |  |
| Neurologic |  |  |  |
| Muscular |  |  |  |
| Balance |  |  |  |
| Orthopedic |  |  |  |
| Allergies |  |  |  |
| Learning Disability |  |  |  |
| Cognitive |  |  |  |
| Emotional/Psychological |  |  |  |
| Pain |  |  |  |
| Other |  |  |  |

To my knowledge there is no reason why this person cannot participate in supervised Equine Assisted Activities. However I understand that the PATH, intl. 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. OT, PT, SLP, Psychologist, etc) in the implementation of an effective equine assisted activity program.

Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD, DO, NP, PA, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License/UPIN #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kentucky Foothills Therapeutic Horsemanship Center

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

 Participant Staff Volunteer

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Medical Facility; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medications: Y N Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons to be contacted in case of an emergency:

1. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_

2. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_

3. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_

 In the event emergency medical treatment is required due to illness or injury during the process of receiving services or while on the property of the agency, I authorize the Kentucky Foothills Therapeutic Horsemanship Center, Inc. to:

1. Secure and retain medical treatment and transportation, if needed.

2. Release participant’s records upon request to the authorized individual or agency involved in the emergency treatment.

**Consent Plan:**

This authorization includes x-ray, surgery, hospitalization, medication and any treatment deemed “life saving” by the physician. This provision will only be invoked if the persons listed above are unable to be reached.

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

 Signature of parent or guardian if participant is under 18

**Non Consent Plan:** (Parent or Legal Guardian must remain on site at all times during Equine Assisted Activities.)

**\_\_\_\_\_\_\_\_\_\_ I do not** give my consent for emergency medical treatment/aid in the case of illness or injurywhile on the property of the agency

Non Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of parent or guardian if participant is under 18

Kentucky Foothills Therapeutic Horsemanship Center

CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

Although every effort will be made to avoid accident of injury, NO LIABILITY can be accepted by any of the organizations concerned including KFTHC, its officers, trustees, agents, employees, each and every one of its members, volunteers or associates or the property owners upon whose land the therapy sessions are conducted.

I request and consent to treatment that may include therapy and I have discussed this type of therapy with my/my child’s doctor.

LIABILITY RELEASE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant’s Name) would like to participate in KFTHC’s program. I acknowledge the risks and potential of risk for activities involving equines. I feel, however, that the possible benefits of Equine Assisted Activities to myself/my child, or my ward are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs or assigns, executors or administrators, waive and release all claims for damages against KFTHC, Inc., its Board of Trustees, Employees, Instructors, Therapists, Aids, Volunteers, Equines, Equine Owners, Equipment or Operating Site or the Owners of Jacks Creek Riding Stables, or Forgotten Roads Farm for any and all injuries and/or losses I/my child/my ward may sustain while participating at KFTHC, Inc.

“WARNING UNDER Kentucky law a farm animal activity sponsor, a farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.”

I understand that no liability can be accepted by any of the organizations concerned with this therapy.

Dated signatures of parent/guardian or participant of legal age must be included.

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kentucky Foothills Therapeutic Horsemanship Center

PARTICIPANT’S HEALTH HISTORY

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Equipment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adaptive Equipment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate current or past special needs in the following areas;

|  |  |  |  |
| --- | --- | --- | --- |
|  | Y | N | Comments |
| Vision |  |  |  |
| Hearing |  |  |  |
| Sensation |  |  |  |
| Communication |  |  |  |
| Heart |  |  |  |
| Breathing |  |  |  |
| Digestion |  |  |  |
| Elimination |  |  |  |
| Circulation |  |  |  |
| Emotional/Mental Health |  |  |  |
| Behavioral |  |  |  |
| Pain |  |  |  |
| Bone/Joint |  |  |  |
| Muscular |  |  |  |
| Allergies |  |  |  |

PARTICIPANT’S HEALTH HISTORY continued

Describe abilities/difficulties in the following areas (include assistance required)

PHYSICAL FUNCTION: i.e., Mobility skills such as transfers, walking, wheelchair use, driving, etc.)

PSYCHO/SOCIAL FUNCTION ( i.e., Work/school, leisure interests, relationships, family structure, support

systems, companion animals, fears/concerns, etc.)

GOALS: (i.e. What do you hope to gain from participation? What would you like to accomplish?)

OTHER INFORMATION WE MIGHT FIND HELPFUL?

This form was completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KFTHC

Questionnaire for Parents

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Son/Daughter Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Son/daughter’s diagnosis (if any):

1. These are some things I like about my son/daughter.
2. These are some things my son/daughter does well.
3. These are some things my son/daughter enjoys.
4. These are some things my son/daughter does not like.
5. These are some things I’d like my son/daughter to learn.
6. My son/daughter HAS/ HAS NOT had any horse experiences. (Circle one) If your son/daughter HAS had experiences with horses, please describe.
7. The reason we came to KFTHC to be involved with horses is:

KFTHC

Questionnaire for Participants

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (if any):

1. These are some things I like about myself.
2. These are some things I do well.
3. These are some things I enjoy.
4. These are some things I do not like.
5. These are some things I’d like to learn.
6. I HAVE/ HAVE NOT had any horse experiences. (Circle one) If you HAVE had experiences with horses, please describe.
7. The reason I came to KFTHC to be involved with horses is: