Kentucky Foothills Therapeutic Equestrian Center
7822 Hwy 2004
McKee, KY 40447
606-965-2158~mykfthc@gmail.com~www.kfthc.org

No participant may be accepted for therapeutic horsemanship services until all forms have been completed.
Forms are required to be annually updated.
Veterans are NOT charged for their riding lessons. KFTHC thanks you for your service.

# VETERAN PARTICIPANT REGISTRATION FORM

Participant Name: _____Age: _____ DOB: _____

Sex: M F Height: _____ Weight: _____ Diagnosis/Concern: _____

Branch of Service (optional): _____

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 _____

(Veteran 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:** | **Medical/Psychological:** |
|---|---|
| Atlantoaxial Instability- include neurological symptoms | Allergies |
| Coxa Arthrosis | Animal Abuse |
| Cranial Deficits | Cardiac Condition |
| Heterotropic Ossification/Myositis Ossificans | Physical/Sexual/Emotional Abuse |
| Joint Subluxation/Dislocation | Blood Pressure Control |
| Pathologic Fractures | Dangerous to Self or Others |
| Spinal Joint Fusion/Fixation | Exacerbations of Medical Conditions ( ie RA, MS) |
| Spinal Joint Instability/Abnormalities | Fire Setting |
| | Hemophelia |
| **Neurologic** | Medical Instability |
| Hydrocephalus/Shunt | Migraines |
| Seizure | PVD |
| Spina Bifida/Chiari II Malformation/ Tethered Cord/ Hydromyelia | Respiratory Conditions |
| | Recent Surgeries |
| **Other:** | Thought Control Disorders |
| Indwelling Catheter/ Medical Equipment | Weight Control Disorder |
| Medications- ie photosensitivity | |
| Poor Endurance | |
| Skin Breakdown | |

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 Executive 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. |
|---|---|---|---|
| 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

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 injury while 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

VETERAN 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 | | | |

VETERAN 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: _____